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S. Hrg. 103–738

WOMEN'S HEALTH CARE IN THE PRESIDENT'S HEALTH CARE PLAN

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Women's Health Care in the Presiden...

HEARING

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

ON

EXAMINING THE ADMINISTRATION'S PROPOSED HEALTH SECURITY ACT, TO ESTABLISH COMPREHENSIVE HEALTH CARE FOR EVERY AMERICAN, AND RELATED MEASURES, FOCUSING ON WOMEN'S HEALTH CARE ISSUES

MARCH 9, 1994

Printed for the use of the Committee on Labor and Human Resources

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WOMEN'S HEALTH CARE IN THE PRESIDENT'S HEALTH CARE PLAN

WEDNESDAY, MARCH 9, 1994

U.S. SENATE,
SUBCOMMITTEE ON AGING,
OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:07 a.m., in room SD–430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) and Senator Barbara A. Mikulski (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Pell, Mikulski, and Wofford.

Also Present: Senators Boxer, Feinstein, Moseley-Braun Murray, and Hutchinson.

OPENING STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Good morning, everybody. I would like to call to order the hearing of the aging subcommittee.

The purpose of today's hearing is to look at what impact the President's health care plan will have on the health of women in the United States of America.

This is a historic hearing, because I believe it is the first time in American history that the U.S. Senate has held a hearing on what should be a comprehensive benefit package, helping women, that would emphasize prevention, primary care and personal responsibility.

The chairman of this committee, Senator Kennedy, has been a longer supporter of access to universal health care and also ensuring that no population is ever left out or left behind. I believe his championship has helped bring us to this day.

It was also within this committee that the first framework for women's health at the Office of Women's Health at NIH was established, we increased the funding for women's health care in a variety of initiatives, and now we look forward as a committee, working with President Bill Clinton in the areas of a comprehensive benefits package, increasing research, having a public health infrastructure, and making sure that women are treated as full partners in this system and not just as an add-on.

A year ago, the women of the U.S. Senate on a bipartisan basis met with the First Lady to outline our principles. Many of those principles are included in the bill today.

I believe we are at a crossroads on how we deliver health care in the United States, especially when it comes to women. We can

either continue the status quo, or we can have a health care system that women want, can easily use, and will truly benefit from. We can rely either on expensive acute care services or emphasize prevention and primary care. We can focus on disease and illness or, for the first time, recognize that so many things affecting women are natural processes, like childbirth and menopause, and are not to be treated as diseases.

We can continue to think about women's health care as an afterthought, or we can make it a cornerstone of the new system.

I believe the President's health care system does take us to the 21st century and does take the needs of women seriously. We are most appreciative that the President's health care plan meets the principles that we advocated at our meeting with the First Lady and with the President himself. It builds a health care system based on the needs of women. It includes a benefit package that includes a full range of services related to prevention, primary care, and personal responsibility. It is to be delivered in a wide range of community-based settings—the school, the home, the hospice. It allows for a wide variety of licensed providers that meet State licensing standards. It moves toward a comprehensive mental health services benefit, and it includes a full range of reproductive health care services, including family planning and pregnancy-related services.

But there are still questions and concerns that have been raised about the plan and in some ways have actually confused the American people. For example, is the screening coverage for breast and cervical cancer adequate? Are the clinical preventive services like mammograms, Pap smears, screening for STDs, based on clinical and scientific data? Are the recommendations for having breast cancer screening every other year for women over 50 based on science or based on money, the ability to pay for a benefit package? Or does the lack of inclusion of family planning services as preventive services without, copayments and deductions, create unnecessary barriers?

This is why we look to what our colleagues from the administration will sat, as well as providers, and we will listen to some interesting survey information about what is covered now in the private sector.

We want to emphasize that this hearing is about science. This hearing is about what is in the best interest, from a scientific perspective, of a comprehensive benefit package for women.

There were many advocate groups that wished to testify, whether it was NARAL or the National Right to Life Group, whether it was the National Conference of Bishops or the American Association University Women. It is not the purpose of this hearing today to hear testimony from the advocacy groups. There will be other forums for that. Today, it is about science. Today, it is about listening to the providers who will have to deliver the health care, and it is about us being able to understand what is currently being provided in the private sector.

So on this historic day, I would like to turn to my colleague Senator Kennedy, who chairs the full committee, who himself has been a stalwart supporter of including services for women in any health care package.

[The prepared statement of Senator Mikulski follows:]

PREPARED STATEMENT OF SENATOR MIKULSKI

The purpose of today's hearing is to look at what impact the President's health care plan will have on women's health.

I believe we are at a crossroads in how we deliver health care in the United States—especially when it comes to women. We can continue the status quo or we can design a health care system women want and can easily use. We can rely on expensive acute care services or we can emphasize prevention and primary care. We can focus on disease and illness or we can emphasize the quality of life. We can continue to think about women's health care as an afterthought, or we can make women's health care a cornerstone for a new health care system.

The President's health care plan does just that. it takes us into the 21st century. And it takes the health care needs of women seriously, from the beginning.

Almost one year ago to the day, the Senate women and I sat down with Mrs. Clinton to talk about this very subject: women's health care in health care reform. We had a very productive conversation. At the end of our meeting, I gave the first lady a list of my key principles for achieving comprehensive health care reform for women.

I am very pleased to report that the President's health care plan meets every one of those principles: 1) It builds a new health care system around the needs of women; 2) It includes a basic benefit package of reproductive health care benefits that guarantees the full range of reproductive health care services, including family planning, preventive and screening services, as well as the full range of pregnancy-related services; 3) It allows for health care to be delivered in a wide range of settings, such as community-based settings, schools, the home, and hospice facilities; 4) It allows for a wide variety of licensed providers that meet State licensing standards; 5) It emphasizes primary care over specialized treatment; 6) It moves toward providing comprehensive mental health services; and 7) It provides an important first step in providing long term care benefits for older Americans.

But there are still questions and concerns that have been raised about the plan and its coverage of women's health. For example, is the screening coverage for breast and cervical cancer adequate? Are the clinical preventive services like mammography, pap smears, screening for sexually transmitted diseases based on the best clinical and scientific data? Does the plan allow women to choose their own health care provider?

Why for example, does the plan single out in vitro fertilization as the only medical treatment for exclusion?

Or for instance, does the lack inclusion of family planning services as clinical preventive services—exempt from copays and deductions—create unnecessary barriers for low-income women to receiving these life-saving services?

The committee needs to know the answers to these and other questions.

Our first panel, speaking for the administration, will describe how the plan will improve access to service, and the specific benefits available to women under the plan.

The second panel will provide the results of two new national surveys of what health care services are currently available to women and the out-of-pocket costs of noncovered services women receive. We will also hear testimony on the current state of research on mammography screening and breast cancer mortality.

And finally, we will hear from a variety of health care providers their expert clinical and scientific opinion about the type of services and benefits women should have in order to achieve and maintain wellness.

Before we begin, I want to thank the distinguished chairman of the full committee for joining me in cochairing this hearing. I also want to let the witnesses and audience know that I have invited all of the other women Senators to join me at today's historic hearing so that they could have an opportunity to hear your testimony and ask questions if they should have them.

With that, let's begin.

Opening Statement of Senator Kennedy

Senator KENNEDY. Thank you very much, Madam Chair. I would like my statement to be made a part of the record, and I will just make a brief comment.

I think all of us in the U.S. Senate, in the Congress, and across this Nation, owe Senator Mikulski an enormous debt of gratitude for the focus and attention and direction that she has provided on issues of women's health. This has been an extraordinary effort on her part, and at last, we are getting the attention and the focus and the support in a wide range of different issues that affect women in our society. Whether it was the NIH legislation which established the centers for research at NIH, or the range of other policy questions, this has been a really remarkable achievement.

Second, I think it is enormously important to recognize how important the Clinton health program is for women in our society. I think all of us understand that the great majority of individuals who are part-time workers, who are working in small business, who enter and exit the labor market particularly during childbearing years, are the most vulnerable individuals in having their health insurance—if they are fortunate enough to have it—terminated, cut off, or being employed as temporary workers where they do not have it.

President Clinton's program makes it clear that coverage for each and every American is not necessitated in terms of employment status, and that is incredibly important to all Americans, and it has a particular relevance in terms of women in our society.

Finally, I think the dramatic inclusion of the wide range of preventive health care programs that are targeted and focused on women—Senator Mikulski has mentioned Pap smears and mammograms, and we welcome the fact that the Department of Health has just issued regulations on those matters in the last day or so—is enormously important, and they are included.

All of us are looking forward to the continued research that is taking place in ovarian cancer, breast cancer, osteoporosis, lupus,

and the wide range of different diseases that affect women in our society.

This program can be strengthened, and it can be improved. We look forward to the comments of those who will be testifying today. I do think it is important that, as we are reaching the time for making decisions in the Congress, the women of this country speak out and let us know how it can be strengthened and improved, and that they will get behind this program that can make such a difference to them and to their families, to their parents and to their children.

This is an important hearing, and I commend Senator Mikulski for chairing it and for providing the leadership in this area.

Thank you.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Our hearing this morning deals with one of the most serious aspects of the Nation's health care crisis—the unequal access available to the majority of our people, who are women.

It is clear that women are second class citizens in the current system. They are more likely than men to be part-time or temporary workers. They are more likely to work in small businesses or in sectors of the economy where health benefits are not offered by employers. As a result, they are more likely to be uninsured or inadequately insured. More than 12 million American women have no health insurance at all.

Women are also hit harder by our-of-pocket expenditures and by the high cost of health care, because women still earn, on average, far less than men.

Illnesses that are unique to women, or that are more prevalent or more serious in women, deserve more attention than they have receive.

One in eight American women will develop breast cancer at some point in her life. Yet the use of mammography, the most effective method of early detection, is still far too infrequent. Cervical cancer does not claim as many lives as breast cancer, but it is just as serious—and it is preventable and treatable through pap tests.

Women suffer higher rates of clinical depression than men, but most never receive treatment. They were often excluded from clinical research tests, on the preposterous theory that what worked for men would help women too.

Women also have greater need for long term care, because they live longer. They are also often the caregivers for others in need of long-term assistance.

Recently, we have taken important steps to reduce these disparities. S. 1, the first Senate bill of this Congress, the NIH Revitalization Act, which was signed into law last June, was given that symbolic designation for good reason. It expanded research on conditions of main importance to women, including breast cancer, osteoporosis, ovarian cancer and lupus. It also establishes an Office of Research on Women's Health, to oversee clinical trials and monitor the status of women's health research.

The Breast Cancer and Cervical Cancer Mortality Prevention Act, also passed last year, authorizes funds for mammograms and

pap test for low-income women. It also supports a program to prevent injuries and deaths from family violence—a vital step toward reducing violence targeted at women.

Just last week, the administration released its regulations to implement the Mammography Quality Standards Act, establishing uniform national standards to ensure the safety and accuracy of mammograms.

These are important steps. But they pale by comparison to enactment of comprehensive health reform, which gives us the opportunity to do so much more.

Above all, the administration's proposed health care plan will guarantee insurance coverage for everyone regardless of employment status. Women who are not working full-time, who hold jobs without health benefits, or who leave the work force temporarily during their childbearing years will not be left without insurance to pay for needed medical care.

The Health Security Act will also meet the special health care needs of women. The benefits include preventive screening, such as mammograms and pap tests; reproductive health services, including family planning and the full range of services for pregnant women; mental health services; and a new long-term care program. And among the medical research priorities in the bill are a number of conditions unique or especially significant for women.

The administration's plan, in short, will reform our health care system so that it will no longer treat women as second class citizens receiving second-rate care.

In today's hearing, organized under the able leadership of Senator Mikulski, we will hear from a variety of experts on the health needs of women and how the Health Security Act can guarantee that those needs will be met.

Assistant Secretary Phil Lee and Dr. Sam Broder of the National Cancer Institute will discuss the features of the administration's plan that are vital to women's health. The next witnesses will describe current insurance standards and the plight of women. Finally, a panel of medical experts will discuss what is necessary to guarantee adequate coverage for women.

I am particularly pleased that Dr. Susan Troyan, a surgeon at Beth Israel Hospital in Boston and an expert in breast cancer and mammography, is able to join us.

I welcome all our witnesses and I look forward to their testimony.

Senator MIKULSKI. Thank you so much, Senator Kennedy.

I want to emphasize the bipartisan nature of this hearing. Senator Kassebaum, the ranking minority member on the full committee, had intended to be here, but her amendment on aviation product liability is on the floor, and she will come as soon as she can. Also, Senator Gregg has conflicts and will be joining us later on in the hearing, I believe.

As part of this historic hearing and in the spirit of bipartisanship, I invited all of the women of the Senate, our Democratic colleagues and, of course, Senator Kay Bailey Hutchinson, who are not on the committee, to participate, and we will be hearing from them.

But first, Senator Pell, would you like to make an opening statement?

Opening Statement of Senator Pell

Senator PELL. Thank you very much, Madam Chairman, and I thank you for holding this hearing.

As we begin drafting health care reform legislation in earnest, it is imperative that we include in any benefits package services which attend to the real needs of women. For too long, women's health needs have been ignored and given short shrift.

Because of the work that you have done in great part, Madam Chairman, and the members of this committee have done, there is now much more attention paid to the needs of women in medical research, preventive care, and aging. Working together, I think we can ensure that women's health care needs are addressed in a comprehensive benefits package.

I would particularly like to welcome Drs. Lee, Broder and Blumenthal here today. I look forward to hearing from them, and I might add how appreciative I am of Dr. Broder's kindness to me and my wife during a recent family illness. His words of concern and, more important, of advice were of great comfort to me and to my family.

Thank you, Madam Chairman.

Senator MIKULSKI. I would like to call on Senator Wofford, a member of the committee, next, and then on my two women colleagues.

Opening Statement of Senator Wofford

Senator WOFFORD. Senator Mikulski, thank you for this hearing, and Senator Kennedy, for your leadership. I do have an opening statement which I will put in the record so we can get to these very important witnesses.

I would just like to note that we have a medical school, the Medical College of Pennsylvania, that has been involved in women's health care since its foundation in 1850. The Medical College of Pennsylvania is the oldest women's teaching hospital in the country. It has had an established reputation as a pioneer and a pacesetter in the area of women's health care. It has been a leader in addressing the concerns of women medical students, physicians and patients. I would like to put written testimony from them in the hearing record, and I will put the rest of my statement in the record as well.

Thank you.

[The prepared statement of Senator Wofford follows:]

Prepared Statement of Senator Wofford

I commend my colleague, Senator Mikulski for her leadership in the area of women's health and for holding this hearing today along with the Chairman of the committee, Senator Kennedy.

I came to support comprehensive health reform because I saw the harm and pain the current system is causing. Families across Pennsylvania and across the Nation are plagued by insecurity about whether they will have the health insurance they need. And

skyrocketing health care costs are hurting families, making it harder for businesses to compete, and driving up the deficits of cities, States, and the Federal Government. For American women, the need for health reform is critical—the failures of the current system hit women especially hard.

Although women are more likely to use health care than men, they are even less likely to have insurance. More than 12 million women have no health insurance and millions more have insurance that does not meet their basic health needs. Women disproportionately depend on Medicaid for coverage.

Women who do have coverage often experience discriminatory pricing or insurance denial: women under the age of 55 are charged substantially higher premiums than men of the same ages; and pregnancy is considered a pre-existing condition for which women are denied health coverage under many of today's insurance policies.

Comprehensive health reform must guarantee coverage regardless of health status, marital status, employment status, or ability to pay. This guarantee will be a major improvement for many women.

A central element of that reform must be to end our current two-tiered health care system. The Health Security Act proposed by the President achieves this end by bringing people currently covered by Medicaid into the health alliance structure. State and Federal premium subsidies for low-income people will be paid to the health alliances, and they will choose from health plans offered within their geographic area, just as all other Americans.

Millions of women with private insurance do not have coverage for physician care for a routine pregnancy and delivery, nor for routine screenings such as mammograms and pap smears. Under the Health Security Act, women will be guaranteed a comprehensive package of benefits including: a wide range of preventive services; mental health and substance abuse benefits; reproductive services such as family planning, contraceptive devices, and services for pregnant women; and a new Medicare prescription drug benefit to help senior citizens better afford the cost of prescription drugs. Plans may not terminate, restrict, or limit coverage for the comprehensive benefit package in any portion of the plans' service area.

Breast cancer will kill 46,000 women in 1993. Potentially promising research into the causes of breast cancer and links with diet, alcohol, estrogen use, and family history have not be adequately explored because of insufficient funding.

The President's proposal includes the strongest support of all health plans for research concerning women's health concerns: the bill authorizes almost $3 billion in funding for new biomedical and behavioral research on promoting health and preventing diseases, disorders, and other health conditions. Priorities for this funding include breast cancer, research on child and adolescent health (including birth defects), and reproductive health.

Women tend to live longer and require more long-term and home health services that are often not available or unaffordable. In addition, the average caregiver is age 46, female and married, and more than 50 percent of caregivers work outside the home. The

Health Security Act includes a new home and community-based long-term care program, some improvements to nursing home coverage under Medicaid, and improved standards and incentives for private long-term care insurance. States may include respite care for caregivers in their home and community-based care programs. These components will help reduce the undue burden born by many women caregivers.

U.S. health expenditures are over $900 billion. Families and businesses together will pay $7,739 per family for health care in 1993. This figure has tripled since 1980 and, without reform, is projected to reach $14,517 by the year 2000.

Research shows that much of this spending is wasted on unnecessary procedures. For example, while hysterectomy is one of the most commonly performed major surgeries in the United States, studies show that the vast majority of hysterectomies were not medically necessary.

As consumers, employees, and business owners, women will benefit from the Health Security Act's strong cost containment initiatives—including increased competition and consumer choice, incentives to eliminate waste in the health system, and a limit on the growth in premiums. We must control the spiralling health costs that are harming the economy, depressing wages, driving up the deficit, and handcuffing the government—causing too many other important social issues to grow unaddressed. Furthermore, these high costs are attended by poor outcomes, seen for in our infant mortality rate and incidence of preventable diseases.

To improve the value for our health care dollar, we need to better understand the results that can be expected from different courses of treatment. The Health Security Act includes increased Federal support for the patient outcomes research that is critical to moving our health system toward greater accountability. Outcomes research will not only help to eliminate inappropriate or unnecessary treatment, but also can help to ensure that all necessary care is provided.

I look forward to hearing to hearing from our witnesses today to hear their insight on women's health issues and to further our understanding of the importance of comprehensive health reform for women.

Senator MIKULSKI. I have a statement from Senator Dodd to be inserted in the record.

[The prepared statement of Senator Dodd follows:]

PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman, I am pleased that we are holding this hearing today. Women all across America have high expectations for health care reform. They want the same things that men do: Universal coverage and cost control. But they also want a health care system that will not treat their unique needs as an afterthought.

Women often need specialized care, and all too often our current system fails to provide it. We must craft a reform package that corrects that failing, and I hope today's hearing will give us an opportunity to hear how we can make that happen.

The first step is to assure all Americans universal coverage. Today, 19 percent of women between the ages of 15 and 44 have

no health insurance. Going uninsured is particularly perilous for women of this age, according to recent study released by the Women's Research and Education Institute. In addition to regular health care, these women often require special reproductive and preventive care services.

Health care reform should also make cost-saving preventive care available to all women. Today, even women with private health insurance coverage often have limited access to important preventive care services, and individual policies can leave out pregnancy coverage.

According to a 1990 survey, close to 30 percent of women with private insurance do not have coverage for pap smears, an important way to detect and prevent cervical cancer. Twenty percent of private policies do not cover mammograms, a procedure key to the early detection of breast cancer.

Our present system's neglect of preventive medicine becomes startlingly clear when we examine prenatal care. We all know that the United States has a dismal record on infant mortality. We all know that every dollar spent on prenatal care saves three down the road. In the face of these clear and widely known facts, our health care system continues to neglect this most basic of preventive health measures. Women continue to suffer needlessly, and babies continue to die needlessly.

I look forward to hearing from our witnesses this morning about these issues and others related to women's health.

Senator MIKULSKI. Senator Boxer?

OPENING STATEMENT OF SENATOR BOXER

Senator BOXER. Thank you so much, Madam Chair and to the full committee chair. It is really an honor for me to be with you on a subject that I care deeply about, and I know you care very deeply about.

When we talk about health care for women, we are talking about health care for more than 50 percent of our Nation; so more than any other group, women are going to be impacted by the decisions that you make here and we make on the Senate floor, and of course, in the other body, in the House of Representatives.

There are 12.7 million in the United States between the ages of 18 and 64 who are uninsured. So the President's Health Security Act goes a long way toward resolving this problem, and we have to stick with that aspect—universal coverage, a set of benefits that can never be taken away.

The President's guaranteed benefits package ensures coverage for the full range of reproductive health services, including family planning, and it protects a woman's right to choose. It requires no copayments or deductibles for a core set of preventive services which in my view will save us money in the long run. It offers Pap smears, prenatal care, and mammograms. It also, in my view, improves access to all by making obstetricians and gynecologists primary care providers. I think this is crucial. If there is one thing I have learned, Mr. Chairman and Madam Chair, as I have gone around California, it is how many women literally have no other doctor than their gynecologist/obstetrician.

I think that there will be those who will try to play politics with these issues and argue, for example, that a woman's right to choose should not be included in the package. I think we have to be clear, and I think we will find out today that the vast majority of insurers do include a woman's right to choose. So we are not talking about a new benefit here. We are talking about not going backward. We cannot go backward.

Finally, I have some concerns about the limitations for coverage of pelvic exams, Pap smears and mammograms in the President's bill. These decisions must be based on the highest medical standards, and surely on complete scientific evidence, not on partial studies. Before I am a Senator, I am a woman. I know too many women who have died of breast cancer, who have had breast cancer, who will get breast cancer. So we must make these decisions very carefully, because if we do the wrong thing, we are going to cause a lot of suffering.

So Madam Chair, I want to tell you how much I appreciate your leadership. The fact that you included the women of the Senate in this hearing and the fact that the full committee chair did as well is pretty extraordinary, and I will work closely with this committee and do all I can to help you in getting the best and finest bill that protects the health of all Americans, including women.

Thank you.

[The prepared statement of Senator Boxer may be found in the appendix.]

Senator MIKULSKI. Thank you, Senator Boxer.

Senator Feinstein?

OPENING STATEMENT OF SENATOR FEINSTEIN

Senator FEINSTEIN. Thank you very much, Senator, and thank you very much for asking me to be here as well. I very much appreciate it. And thank you very much, Senator Kennedy, as well.

One of the things that impresses me very much is to see the number of people in this room this morning. I think it is really testimony to the fact that people do care about women's health, and they are not all women in this room. I really want to thank them for this because, as Senator Pell said, women have gotten the short shrift, and I think people should know that this past year, thanks to Senator Kennedy and to his committee, there has really been a major change in the way this Nation looks at public health and personal health for women. I will go into that in just a moment.

At present, women's health care is still inequitable. In my own family, I have got young people who are healthy, but cannot get insurance because of pre-existing conditions. Because many women work in low-wage jobs, because they change jobs and take care of children, women are more likely to live in poverty in this country, and so they have limited access to regular health services. And that includes prenatal care, it includes mammograms, it includes other preventive services.

I am particularly anxious to hear from Dr. Lee this morning. Dr. Lee is an old friend. You might be interested to know, Madam Chairman, that when I was mayor, he was president of my health commission, the health commission of the city and county of San Francisco, and did a really excellent job. I think he is one of the

Nation's authorities on public health, so I am delighted that he is back here in Washington.

I think we have to remember that two-thirds of all part-time workers in this Nation are women. In California, about 7 million people have no health insurance at all; 75 percent of them are employed, and the great bulk of them are women. So what we are doing in health care reform is probably going to impact women almost more than any other group. Nationwide, only 37 percent of all women get their health insurance through an employer; only 37 percent.

AIDS is a critical issue for women. They are being infected at increasing rates. And the cost of health insurance today is higher for women than it is for men. Because women live longer than men, they often face additional barriers to receiving health care coverage—the expense of long-term, home health services—and they are directly affected by changes in Medicare.

As a result of these circumstances, too many women are often denied basic care. That includes reproductive and family planning services. I am hopeful that the Congress is going to understand these issues.

I mentioned that a great deal has been done in the past year. I think this committee of the Senate, with Senator Kennedy's leadership and Senator Mikulski's leadership and others, is really responsible for that.

Restrictions on access to abortions for Federal employees—all of us have worked for that. Increased funding for breast cancer research is up 40 percent from the previous year. It is a record $296 million. These are anonymous figures, but all of us know people well, as Senator Boxer alluded to, who have breast cancer, who have ovarian cancer. Many of us have close friends who are in the terminal stages of these diseases at the present time.

Funding for women, infants and children has gone up 11 percent. Women will now be included in clinical drug trials. I think many of us were astonished to find out that that has not been the case. And in the coming year, hopefully, the Women's Health Equity Act, sponsored by our dean, Senator Mikulski, will have enough momentum to move. Some 32 separate bills have been authored by various members, including all of the women here in the Senate.

I think as we look ahead, we have got to turn to women's health equity and specifically how the health care plan now under discussion addresses these needs. In addition, I think questions remain about the affordability, the accessibility, the frequency of clinical and preventive health care services provided in the Clinton plan or any other plan.

The President's bill is precise in describing what will and what will not be included, and this really stands in stark contrast to other health care bills. I believe that whatever adjustments or compromises are made in the health care debate, whatever the product of hearings is, whatever the combination or the compromises are, women's health care must not only have equal standing, but the special needs of women must be met by whatever the vehicle.

So with my colleagues, I will be watching these issues. Again I want to thank you, Senator Mikulski, for holding this hearing and

for my colleague being here, and Senator Kennedy, for all your work this past year and these great achievements.

Thank you.

[The prepared statement of Senator Feinstein may be found in the appendix.]

Senator MIKULSKI. Thank you, Senator Feinstein.

We will now turn to our first panel which consists of distinguished physicians from the administration to address how the plan will improve access and the specific benefits that will be available to women.

Our first witness is Dr. Phil Lee, who is the Assistant Secretary of Health and head of the Public Health Service, and who brings to his post an enormous background in health care and in public health policy. Dr. Lee will be accompanied by Dr. Susan Blumenthal, who is the deputy assistant secretary for women's health within HHS. She herself is a distinguished psychiatrist and is chief of behavioral medicine and preventive research at the NIH Institute on Mental Health. And in fact, all of our mental health was improved, Dr. Blumenthal, with your appointment.

And finally, we will hear from Dr. Sam Broder, who is director of the National Cancer Institute at the National Institutes of Health, who will be talking about issues related to prevention and treatment. Dr. Broder has been a long-time supporter in this area.

We will be following a 7-minute rule for questions by my colleagues, as indicted by the lights.

Dr. Lee, please proceed, and then we will listen to Dr. Broder, and we know Dr. Blumenthal will help with the answers.

STATEMENTS OF DR. PHIL LEE, ASSISTANT SECRETARY OF HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DR. SUSAN BLUMENTHAL, DEPUTY ASSISTANT SECRETARY FOR WOMEN'S HEALTH; AND DR. SAMUEL BRODER, DIRECTOR, NATIONAL CANCER INSTITUTE, NATIONAL INSTITUTES OF HEALTH

Dr. LEE. Thank you very much, Madam Chairman. I am very pleased to be here with Dr. Broder and Dr. Blumenthal, and I am particularly pleased that my two Senators from California are here today.

I will be testifying on the women's health and health care aspects of the Health Security Act, S. 1757. Your emphasis on health, I think, is very important as the Health Security Act is, perhaps more than any of the other proposals before the Congress, one that emphasizes health as well as health care and health care financing.

The Act is particularly important for women because, as Senator Kennedy pointed out, and Senator Feinstein and Senator Boxer particularly, women are disproportionately affected in the present system by a number of factors that diminish their access to care. They are less likely to have health insurance. They are more likely to lose their insurance because of part-time employment or dependence on their spouses or insurers. They spend more out of pocket for health services. Clinical preventive services which are particularly important for women are often lacking in health plans even when other services are covered. Mental health benefits, including

prescription drugs to treat such problems as depression, are often inadequate in present plans.

Over 2 million uninsured children under age 18 live in households headed by single women who bear the major responsibility for the health needs of the children. And, as Senator Feinstein pointed out, women are the principal informal caregivers for the disabled elderly who require long-term care services, and they themselves live longer and are more likely to require these services, and most of these are uninsured today, particularly the kind of home and community-based services that are included in the plan.

I think it is important to note that over this weekend, actually, the Older Women's League, which is concerned about women of all ages, announced its support for the President's plan, and the Campaign for Women's Health also endorsed the President's plan. So I think those are important indications that we do address in the plan major issues such as those that I have enumerated.

How do we do that? First, by guaranteeing every American health insurance protection regardless of health status, employment, income, or age. Regional and corporate alliances and the health plans will be responsible for making sure that everyone will have access to the guaranteed benefits. They will have choice of plan—and this is a particularly important role, as I see it, for the alliances; they really are purchasing cooperatives that will help us all have greater choice of plan.

We will also receive through the alliances and from the plans information about the quality of care provided in the plans, the quality report cards, that will make our choices about which plan we want to choose better choices.

The benefits of the Health Security Act are specified in the Act, and they are particularly important for those with chronic illness and who require services. Both the patient and the doctor will know what benefits are provided when Congress specifies the benefits. Many have said we should leave it to the national board. By Congress making that clear, the patients will know, the plans can be adjusted on whether they are providing the benefits, and the doctors will know when they are prescribing for their patients. So it has a big advantage. It also has the advantage that these costs can be estimated.

It is important as well that this specified benefits package prevents the kind of insurance practices we have seen where those who get sick may get exclusions, where there may be experience rating, there may be other factors that limit access even for those who are insured.

The full range of pregnancy-related services are covered in the plan. To encourage their use, the plan covers prenatal care and one postpartum visit with no cost-sharing. Voluntary family planing services, including all contraceptives approved by the FDA and dispensed by prescription will also be covered in the plan.

As with these services and other pregnancy-related services, choice of medically necessary and appropriate reproductive health care services will be left to the woman and her health care provider.

Clinical preventive services are an important part of the benefit, as we have all noted. These include clinical exams at periodic intervals, immunizations age-appropriate, Pap smears, pelvic examinations, blood cholesterol tests, and screening mammography every 2 years for women over the age of 50. This policy was first recommended in the United States by the U.S. Preventive Services Task Force in 1989. It was recommended by the precursor Canadian Preventive Task Force in 1979. And no other country in Europe or in Canada provides screening mammography for women under the age of 50. I think that is an important fact for us to be aware of.

Mammograms, however, for diagnostic purposes, when ordered by a physician, are included whenever it is considered medically necessary and appropriate as part of all the plans. I think that is a very important point that has tended to be obscured in the debate recently.

In the low cost-sharing plan, there would be no cost-sharing for these diagnostic tests; for the higher cost-sharing plans, there would be a deductible, which is limited to $200 per individual or $400 per family annually, and a 20 percent coinsurance payment.

As important as the specific clinical preventive services included in the plans are, the incentives in the plan, the capitation payments to the plan, these payment plans provide an incentive for the plans to keep people healthy. They also provide incentives for plans to link with public health agencies so there would be shared public health goals between the health plans and the public health agencies. This, I think, is one of the unique features.

The mental health benefits in the plan are particularly important for women because many common mental illnesses, including depression and some anxiety disorders, strike women approximately twice as often as they strike men. Both the mental health benefit and the prescription drug benefit which would cover prescription drugs needed to treat such conditions as depression are an important part of the Health Security Act.

The long-term care benefits are included, and they increase incrementally, therefore, both disabled over and under 65. They are a federally supported State plan and are beginning to deal with this very serious problem. They are not the final solution, but they are certainly an important step.

Let me close, Madam Chairman, with a few words about Title III, which are the public health initiatives in the plan including prevention research at NIH with significant research focused on issues relating to women, maternal and child health, Alzheimer's disease, and cancer, among others; second, the access initiatives for undeserved populations, and strengthening the public health system. All those have been detailed in previous testimony before this committee, the full committee.

In conclusion, Madam Chairman, I want to thank you for the opportunity to testify and to be joined by Dr. Blumenthal and Dr. Broder on the critical issues related to women's health. We will of course be pleased to work with you to answer any unresolved questions or issues, and we look forward to this historic opportunity to provide health care with real health security for all Americans.

Thank you very much.

[The prepared statement of Dr. Lee may be found in the appendix.]

Senator MIKULSKI. Dr. Broder?

Dr. BRODER. Good morning, Madam Chair and members of the subcommittee. I am Dr. Sam Broder, director of the National Cancer Institute. Thank you for the privilege of appearing before you today to discuss the research mission of the National Cancer Institute and to provide assistance in outlining how our basic and clinical research, how our outreach activities, how our community service commitment, and our minority enrichment programs play a role in the forthcoming health care debate and in the health care reform agenda.

I want the record to show that I do not take any paranoid reaction to the fact that every time I testify, or frequently, every time I testify, a psychiatrist is sent with me. [Laughter.]

Senator MIKULSKI. And you have a social worker chairing.

Dr. BRODER. Indeed, I think there is a message there, but I do not know what the message is.

With your permission, I will submit remarks for the record. My written remarks provide detailed information regarding a number of issues related to cervical cancer and breast cancer and other issues related to women's health. In my written comments, I discuss information regarding the issues of screening, diagnosis, treatment and, most important of all, prevention. But in my opening comments for oral presentation, I want to emphasize a few brief points.

The NCI is a scientific institution in the best use of the term "science," not just laboratory science, but knowledge generated to alleviate suffering and death from diseases. We are a biomedical research institution committed to generating the knowledge needed to reduce suffering and death from cancer and other illnesses that are within our mission.

The generation of knowledge is certainly not confined to basic research laboratories. We generate knowledge in multiple ways and at multiple levels, and we do so in the lab, in the clinic, and at the community level. We are not a regulatory agency.

While at times there have been bursts of enthusiasm for research advances that promise to cure cancer, we all recognize that cancer has not been cured. Today, there are exciting developments on many fronts, particularly in basic research, but as we discuss these achievements, we must acknowledge that cancer poses an awesome research and therapeutic challenge. We must have no illusions on this point. Therefore, we need a strong and durable commitment to a research agenda in prevention and treatment.

Moreover, we at the National Institutes of Health in general, through our basic and applied research programs, can develop new knowledge that in a paradoxical way can generate inequities in the larger society.

If we do not have universal coverage and universal access, please let me explain what might happen. As lifesaving interventions are developed, and at the same time, if certain undeserved groups, if women, if minorities and if poor people do not have access to the new knowledge and new technologies that are generated, their health statistics may actually get worse compared to other groups that do have such access. And I could—although time will not per-

mit me to do so today—provide you with demographic evidence that that in fact is happening.

Therefore, a knowledge-generating institution can paradoxically generate inequities in society that might not have existed prior to the generation of the knowledge.

In addition, we have funded research which has applications in broad arenas, many of them unforeseen. Madam Chair, for example, at Johns Hopkins University in your own home State of Maryland, investigators have recently identified a new gene connected with certain forms of hereditary colon cancer. But interestingly enough, this gene is also associated with certain forms of endometrial cancer and ovarian cancer, to name a few. Thus, in the broadest sense, what might not have initially appeared to be a women's health research issue is actually a research issue that is fundamental to women's health, and we are very proud of this kind of research.

We have also a significant role to play in information and dissemination. Historically, the National Cancer Institute has played an important role in establishing certain broad guidelines as they affect women's health and disseminating knowledge at large.

Senator Pell, I want to acknowledge the wonderful support you have given to us in our international research agenda for knowledge generation.

Senator PELL. Thank you.

Dr. BRODER. But our guidelines are simply an attempt to distill the best knowledge that we have. They are not a regulatory process. We feel that in the matter of practice guidelines, the NCI, while having much to offer, particularly on the issues of randomized clinical trials and scientific consensus, must make a special effort to work in concert with other relevant Government agencies and avoid independently attempting to set on a regulatory basis de jure or de facto health care policies.

Finally, I want to pick up on a theme I heard from Mrs. Clinton, our First Lady, and this is also a kind of warning. As the Human Genome Project, with which the National Cancer Institute is attached, but which is an entity within the National Institutes of Health, proceeds, we will to certain knowledge identify more and more genes that predict for the future emergence of various diseases in all of us, not just cancer, but across the entire broad health array. As we identify genes that can predict the future development of a disease, I hope that everybody thinks about the implications. We will, all of us, every man and woman in this room, to certain knowledge eventually be found to have a pre-existing condition. Does that imply that none of us will be insurable?

I believe there is much we have to offer and look forward to the exciting challenges. I consider it an extreme privilege to be here before you to provide information. Thank you for the opportunity.

[The prepared statement Dr. Broder may be found in the appendix.]

Senator MIKULSKI. Thank you very much, Dr. Broder.

I would also like to acknowledge that we have been joined by our colleague, Senator Carol Moseley-Braun of Illinois. We understand that Senator Braun wanted to show her support for the women's

health initiative but is also on her way to a meeting at the White House.

I also believe, Senator Braun, you are accompanied by a distinguished American physician. Senator, would you like to just say a few words and introduce the person who is accompanying you today, and then we will return to the questioning of our witnesses.

OPENING STATEMENT OF SENATOR MOSELEY-BRAUN

Senator MOSELEY-BRAUN. Thank you very much, Madam Chairman.

I would first like to congratulate and thank you for convening this hearing and for all of your hard work in regard to the women's health initiative and health care reform in general. You and I had an opportunity this morning to chat about this hearing today.

Senator Kennedy in fact just left a meeting that I had this morning with the National Medical Association, which is the oldest African American professional organization in the country. It is a physician provider organization, and they were in to discuss health care reform in general, and in specific the concerns of the minority communities and also the concerns that are being addressed this morning at this hearing.

So Madam Chairman, as you know, I am headed over to talk with the First Lady, Mrs. Clinton, about health care also, so it has been a health care morning for me, and what I would like to do is to have my statement to this committee received for the record, and also, if you would, I would like to introduce for the record as well the paper by the National Medical Association in support of health care reform that speaks specifically to some of these issues.

Senator MIKULSKI. Without objection.

[The prepared statement of Senator Moseley-Braun and related article may be found in the appendix.]

Senator MOSELEY-BRAUN. I would like further to briefly introduce this morning members of the National Medical Association to this committee.

Dr. Gloria Jackson-Bacon, from Chicago, IL, runs a clinic in what is known as Algill Gardens and has been in the forefront of the struggle for health care reform. Dr. Bacon was here this morning to discuss health care reform and the position of the NMA with us.

Also, Dr. Meva Lubin is the president of the Prairie State NMA branch, and she brought with her a delegation that is assembled in the back. I cannot go through all the names, but they are here today to discuss health care reform in general and to also have the opportunity to sit in on this hearing.

So again, I just want to file this information for the record, to thank you for your courtesy and kindness in allowing me to participate this morning, and to apologize for running out—it is the old, "Hello, I must be going" routine. But I want to tell you that I really want to support you in everything you are doing with regard to the women's health initiative.

Senator MIKULSKI. Thank you very much, Senator Moseley-Braun, and we want to acknowledge the significant role that the National Medical Association has played in American history in the provision of health care. I believe that they have labored long, for more than a century, in providing health care to those who do not

have it while at the same time that they suffered undue burdens in their ability to deliver that health care. And now, I believe we have gone from segregation to an opportunity for empowerment, and we welcome additional conversations with the National Medical Association.

Senator MOSELEY-BRAUN. Thank you, Madam Chair.

Senator MIKULSKI. Now, if I may, turning to you, Dr. Lee—and we will follow a 7-minute rule here this morning—first of all, I want to recognize what I believe are the really great things about the Clinton benefit package.

No. 1, it strives for universal coverage, which is important to women, because so few women have coverage except through their spouse and are often left out, or work in jobs where health insurance is not provided through the employer.

Second, it is portable.

Third, besides the pre-existing conditions, women also have predictable future conditions, like pregnancy and menopause, that are often viewed as diseases. We view them as natural processes, but they require a partnership with the professional provider community.

Also, it has a single comprehensive benefit package that will be available to all Americans—we will not have one little benefit package in one State or one employer. It will be available to all.

We also thank you for recognizing the issues related to long-term care and mental health for women and the roles of women as mothers and as caregivers often for elderly or handicapped persons.

So we think those are among the fine elements to the Clinton plan. I would like to, though, turn to something that I think has created a great deal of confusion in the community, which is the issue related to clinical preventive services.

First of all, we thank you for even considering mammograms, Pap smears, and screening for sexually-transmitted diseases as part of that. However, as you know, Doctor, there is now concern over, first of all, the mammogram coverage coming every other year over the age of 50 when other organizations related to cancer prevention and early detection have recommended mammograms every year at the age of 50. Then, second, women between the ages of 40 and 49 are often recommended to have mammograms—I had my own first one at 40—and then also the issues related to younger women where there is a family history of propensity.

Could you tell us why the Clinton plan decided on this package, because there seems to be confusion over particularly mammograms every other year for women over 50 as well as not providing mammograms at all for women between the ages of 40 and 49. Is this scientific? Is it that we could not afford it? What is the reason?

Dr. LEE. Well, I would say first of all, Madam Chairman, with respect to women over 50 and the frequency, the evidence about whether every year or every other year produces a better result—in other words, detects more cancer—the evidence is really equivocal. And the recommendations of the clinical preventive task force were considered as we reviewed the benefit in the plan. And that is simply a judgment call. It would increase the cost somewhat to do it every year.

I think the major point that has to be made is that we must do it on women over 50. Women over 50 have not been getting mammograms. There has been a great deal of emphasis, as you know, on the issue of women ages 40 to 49, and more of the younger women in fact have been getting mammograms. But the cancer rates, of course, are much higher in women over 50.

So I would say it is a combination of the best evidence and then a judgment call, and we want to provide this committee, of course, with that evidence, and it is ultimately the judgment of the Members of Congress who will make that benefit decision.

Second, with respect to women 40 to 49, the recommendation that we adopted there, not to include that for screening purposes—and I emphasize, screening, not diagnostic mammography when a doctor fees it is medically necessary and appropriate. Those are two quite different things. For the screening mammography, first of all, the Canadian task force in 1979 did not recommend it. The U.S. Clinical Preventive Services Task Force did not recommend it in 1989. It has not been recommended or used in Canada, England, France, Germany, or other European countries. So based on what we considered to be the best evidence from these bodies that reviewed it, we did not include that provision.

Now, for women who are at risk, of course, you have a different situation. There, for example—and this could be in the future—the National Board could make a decision that for this benefit, those women could be included. We could identify specific risk factors.

Age is the most significant risk factor in breast cancer. If we find, for example, the gene for breast cancer, clearly you are going to be screening women at a younger age than we do today. As technology improves, and we find with clinical trials and controlled trials that we can identify breast cancer in women from 40 to 49 effectively, then those benefits could be added.

I would say that currently, it is a question that the review of the evidence did not indicate that that benefit as a screening benefit should be provided from 40 to 49.

Senator MIKULSKI. Well, Doctor, let me say this. First of all, we acknowledge the science that has been presented. But women have been facing two issues—one, the danger of cancer, and the other, the danger of attitudes toward women and their health care needs.

First, we have found that the scientific community, first, was not really too actively engaged in research on breast cancer. That is why there was such an enormous push by this committee and the Congresswomen's Caucus at NIH, and we believe we are on the right track. So when we cite 1979 and 1989 studies, we think that those are not sufficient.

The second thing is that other studies have shown that doctors are even now recommending that women go for early detection screening tests that are available either for Pap smear or mammograms, that they are less likely to be told by a primary care physician, this is what you need and at what age group.

Now, with what is being recommended in the benefit package, we are concerned that once more those bad habits and those bad attitudes will be reinforced by the complicated nature of the recommendations. We are concerned about not only the adequacy of

the benefit package, but also the attitudes that will be inculcated, and that once more women will not be referred for these tests.

Could you comment on that and how the administration intends to deal with that?

Dr. LEE. I would say first of all, for women over 50—and this is the most important group—we absolutely must have a major effort, an educational campaign, not only to educate the providers, the physicians or the nurse practitioners or the other providers, with respect to the benefits of screening mammography, but we have to provide that for patients as well.

Now, one of the advantages of the Clinton plan is that there will be a quality report card. We will see in that report card how frequently do they do mammograms in plan A versus plan B versus plan C. If a plan does not measure up to what we think should be the standard, that plan can be disqualified if it does not meet the standard. In other words, a State has to set a standard that a plan has to meet in terms of quality. Mammography will certainly be one of those standards. So that will be a third mechanism—physician education, nurse practitioner education, consumer education—but specifically holding plans accountable for achieving these objectives as well. I think those measures certainly will be helpful.

But you are absolutely right in terms of what has been the past practice, and I think that you also make a very good point that by having some of these fine discriminations, based on what we think is the best science, it may be sending a very confusing message, and it may be that as you examine that, you will decide that it is better to send one clear signal with respect to mammography and not these different signals that we would recommend based on the scientific evidence, because again, it is a matter of judgment in the end and achieving the goal of providing this screening service—now, I am not talking about diagnostic mammography, but the screening mammography—in a way that reaches the women who need to be reached so they can get treatment at the earliest possible time and get in many cases cured—and Sam can give us, I think, the statistics on what we could achieve if we could get adequate levels of mammography screening for women over 50. It is a very significant impact if we achieve that.

Senator MIKULSKI. When can we expect the strategy on breast cancer to be finalized? We remember the summit that was held at NIH and the robust conversations that went on.

Dr. LEE. Dr. Susan Blumenthal is coordinating that effort for the Secretary, and she can give you a response to that.

Susan?

Dr. BLUMENTHAL. The National Breast Cancer Action Plan that you are talking about is currently out to the cochairs who were present at the meeting for their comment. When we get those comments back, it will be finalized and then ready for distribution.

Senator MIKULSKI. What is the anticipated time?

Dr. BLUMENTHAL. I would say that within the next month, it will be completed.

Senator MIKULSKI. So can we look forward to it by April 1st?

Dr. BLUMENTHAL. I would hope so, yes, absolutely. And we will be holding a meeting on March 23rd when the Secretary will be meeting with other departments of the Federal Government to get

their input about what they are doing in terms of breast cancer research.

Senator MIKULSKI. Well, we know that sometimes we can also analyze it to look for the perfect strategy instead of the best strategy. Dr. Blumenthal, under your leadership, we really look forward to this being promulgated or arrived at by April 1st or sometime within the month, and we are looking forward to having a conversation.

Senator Kennedy?

Senator KENNEDY. Thank you.

I, too, want to join in welcoming this remarkable panel. Dr. Broder leads the Nation's efforts in the area of cancer. Dr. Lee has been involved in health care and health care policy issues as a teacher/academician and has an extraordinary record. And Dr. Blumenthal has had a remarkable career in terms of health policy and in hands-on kinds of health delivery systems. So we are very grateful to all of you.

Am I not right, Dr. Lee, that one of the attractive aspects of the President's benefit package is that it is a "living" package in terms of the preventive health care programs. And as we move on through, there may be some differences, and I think you can detect there are, with regard to mammography and perhaps some of the other programs, but one of the very essential aspects of the President's program is that it is going to be an ongoing and continuing and evolving benefit package in the area of preventive health care. So as we move through in terms of science, those kinds of recommendations in the area of preventive care will be included. We may have some differences with regard to this specific one, but isn't that a feature of the program which is really very unique as compared to others?

Dr. LEE. Absolutely.

Senator KENNEDY. So wherever we come out, we look forward to it. I am always interested when, as a member of the Appropriations Committee, Senator Mikulski asks about a month, and you agree to 2 weeks on it—you can understand how she stretches the resources around here on worthwhile projects. But isn't that something that the American people ought to understand, that this is not something that is just locked in, but is evolving and continuing. And I imagine there will always be tensions about whether things should be in or not, and I think everyone here feels strongly about the preventive aspects of health care, but isn't this a feature of it?

Dr. LEE. You are absolutely correct, Senator Kennedy. And of course it will be based to the best extent possible on the science base. Dr. Broder mentioned the recent advances at Johns Hopkins with respect to the gene for colon cancer. As that evolves, and we get a method for that screening, and it is proven to be a sound method, that of course would be included as a screening procedure. And as there are other advances, we would include those in the clinical preventive services package.

Senator KENNEDY. Dr. Broder, I was enormously impressed by your comments about how, as you make progress in research, that increased knowledge may work in a way that ultimately disadvantages some groups.

Dr. BRODER. That is absolutely true.

Senator KENNEDY. I have 7 minutes here, and I want to get to a couple of other items, but could you just elaborate on that for a couple minutes?

Dr. BRODER. Senator, the very best example of that is in colo-rectal cancer, where there was a time in this country where African American citizens actually had a lower rate of death due to colo-rectal cancer, particularly under the age of 65. So that in the 1930's and the 1940's, you would have said that African Americans would have actually had a lower rate of death due to colo-rectal cancer compared to the white population.

Sometime during the early 1970's, the death rate figures actually crossed, and the death rate for white Americans is falling at a steady rate. It is not fast enough for us; I do not wish to convey to you the impression that we are satisfied with the reductions. But at least within the white population, particularly under the age of 65, there is a downward, unbelievably statistically significant drop. And yet for African Americans, the death rate is actually going up, and the curves are pulling apart.

We think that what is happening is that in one era, the technology was not there, the interventions were not there, and so on, and there may have been other factors that may have actually in one era protected African American citizens from colo-rectal cancer, but for a variety of factors, that was lost.

The intervention aspects are not being made available—early diagnosis, early intervention, cultures for stool blood and so on, flexible sigmoidoscopy, and other technologies that became available are not being made available. There is a disenfranchisement of access, and we are actually—we in the national cancer program, in a way that I do not wish to be misunderstood—we are actually driving a differential because as we make knowledge available, as we make interventions available, if only some have access to that knowledge, we will actually generate inequities. I promise you, that is the future unless we have universal access and universal coverage.

Senator KENNEDY. Well, I have heard many, many arguments for universal coverage, and this is certainly one of the more important ones and one that I do not think our society has focused on, and your examples in this area are enormously important for us.

Could you describe what has happened in some States—for example, Hawaii, which has an important preventive program in terms of breast cancer. As I understand, they do a remarkable job in detecting it and also in reducing morbidity. So the extent that you can give us some other examples in other States, I would appreciate it.

Dr. BRODER. Senator, I think that is a very good point, and I am glad you brought up the situation in Hawaii. There, we are seeing another microcosm of exactly the same phenomenon. The native Hawaiian population has a very high rate of breast cancer and breast cancer death, and the Caucasian population within Hawaii actually has better statistics; and there are other examples of that. We see this as a pattern. I am not going to tell you it is universal, and I cannot use this to explain every, single thing. But we can explain this on a number of factors, and if you will permit me a 30-second digression, one of the defining events of my career was

hearing you speak about your own personal experience, where you heard the parents of other individuals suffering a similar situation to that in your own family—and I do not think I am exaggerating—essentially begging their doctors for their lives, asking their doctors, "I cannot afford the full chemotherapy treatment; can you just give me a 50 percent amount?" I believe I am accurately paraphrasing your story, although not with the eloquence of your initial presentation.

Senator KENNEDY. Yes.

Dr. BRODER. I believe that that was a source that induced a tremendous sense of shame in me, that individuals would have to beg for their children's lives on the basis of an economic issue. And that again was something that reminded me what is the use of us generating a new intervention or a new form of adjuvant therapy for breast cancer or whatever, if only some individuals will have access to it. We will drive differentials. We will definitely be a force of inequality in this country. And then people will ask why did this happen, and why did this happen. But I am saying that it is going to happen; it is very obvious.

Dr. LEE. This is another area, Senator Kennedy——

Senator KENNEDY. Well, let me just move along; I am watching the clock. Let me ask you about a different area. Part of the problem is that we do not give focus or attention to women's health issues in our medical schools and in other kinds of training facilities. I am interested in how you perceive, in terms of the administration's program, what sensitivity are you demonstrating, or what can we do, or how can we be helpful in terms of moving into the total education program greater sensitivity in terms of this range of different women's health issues. Should we be doing it? Are there ways that we can do it better? Maybe you could speak briefly to that, and perhaps Dr. Blumenthal could comment as well.

Dr. LEE. Just a quick word on that. Of course, the Federal Government does not get engaged in curriculum in medical schools, but I think we can have policies that stimulate or provide incentives for these kinds of educational programs. They absolutely have to be done in medical schools, in nursing schools, in pharmacy schools, in dental schools, schools of allopathic and osteopathic medicine.

Senator Mikulski pointed out earlier the lack of adequate training programs and the fact that women are not getting, for example, advice about Pap smears or mammography, as an illustration of how we have not done the job.

We need to do this at the resident level in terms of graduate medical education, where we will, I think, have some significant impact on policy, as well as in the undergraduate professional areas. That is going to take leadership on our part. I do not think it is going to take mandates, but I think we can do a lot more than we have done.

Susan?

Dr. BLUMENTHAL. Actually, my office in collaboration with the National Institutes of Health and the Health Services Research Administration, HRSA, will be working to develop a curriculum on women's health and to do a study to really see what kinds of women's health issues are being studied. When I went to medical school, we learned about the 180-pound man, his anatomy and his

physiology, and all the diseases that affected him, but I can assure you he never went through menopause or had ovarian cancer.

Thanks to Senator Mikulski's leadership, we have seen women's health issues catapulted to public attention, and thanks to your distinguished leadership, Senator Kennedy, we have seen the improvement of the health of all Americans in this country.

We have a long way to go with women's health, and I think this is an important step forward in terms of trying to create agenda-sensitive curricula that look at how diseases manifest in men and women and how they may or may not be treated differently.

Senator KENNEDY. Thank you very much.

Senator MIKULSKI. Thank you, Dr. Blumenthal.

Senator Kennedy, I believe one of the forward steps taken in the benefit package is who the providers will be. We recognize ob-gyn as primary care physicians—and we will be hearing from them—because for many women, that is who their primary care physician is and their entry into the system, particularly for postadolescent women.

Senator Pell?

Senator PELL. Thank you very much, Madam Chairman.

To me, one of the most important things we can do in health reform is to let people know what they can do to prevent illness and to improve their quality of life and enhance good health. I have not heard too much emphasis on that side of health care in the President's plan. What in the President's plan ensures that women and their doctors hear about the latest scientific developments in what is productive of cancer and what actions are not productive of cancer, and help them in their own households, where they have more exposure to harmful drugs, asbestos, dust, etcetera, than we as men have? What is being done to distribute this knowledge to women?

Senator MIKULSKI. Did everyone hear that with the bells? Did you hear the question, Dr. Lee?

Dr. LEE. I did.

Senator MIKULSKI. Could you repeat it as you answer?

Dr. LEE. Sure. Basically, Senator Pell asked what can we do to provide education to patients with respect to those things that can keep them healthy, those things that relate to health behaviors that can have an adverse effect on health.

There are several things. First of all, in the clinical preventive services, at the time of the periodic clinical exam, counseling with respect to risk behaviors. Second, in the benefit package for particular chronic diseases like diabetes, health education and information would be available, so that there would be opportunities for patient education around those things that will help prevent complications. In diabetes, studies at NIH have now shown very dramatically significant reductions of microvascular complications such as kidney disease from well-controlled Type I diabetes. If blood sugar is controlled by good management that includes insulin, diet, and exercise, there are dramatic reductions in complications. We need to disseminate that information, that needs to be widely applied, and it can be under the plan.

A third thing that is not, I think, easily recognized at the moment has to do with another development, which is the information

highway which is in the process of development. We will have available—and there have already been some extraordinary benefits by providing patients or individuals directly information in their homes through fiber optic networks of information about their condition. They can then determine whether they need or do not need to see a physician.

We know in many cases as much as 30 percent of visits to physicians do not need to take place. The patient, if he or she had the information, could handle the problem without going to a physician or a nurse practitioner or other provider.

Other information could be provided that would help them change their behaviors with respect to things that may have an adverse effect on health that they may not be aware of.

So I think in the long-term, the most significant benefit in terms of these issues may in fact come from the developments of the information highway. And the fact is that we are developing data systems in the plan that will provide information.

And finally, of course, at NIH and at the Centers for Disease Control and at the Substance Abuse and Mental Health Administration and the Agency for Health Care Policy and Research, we will be doing both basic research and applied research to find better ways to communicate this very, very important information, because a key to the President's plan is responsibility, and people cannot be responsible if we do not provide them the information with which to make good choices.

Senator PELL. Thank you. Another thought here is that the quality of life is just as important as the extension of life, and this is where mental illness comes in. If life is extended 10 years, and the individual is miserable, isn't that worse than living for 5 more years in good health?

Dr. LEE. That is absolutely right. Quality of life is key, and it is more important, really, than just stretching it out, particularly if the conditions that the individual is suffering from—let us say Alzheimer's disease or some other chronic condition for which there is no real remediation. But there again is where our research is going to play such an important role in helping us deal with some of those problems that do make the quality of life so tragic for millions.

Senator PELL. Thank you very much.

Senator MIKULSKI. I am going to turn now to Senator Boxer, but first, Dr. Lee, I would just like to make one comment about the information superhighway, which I think offers dazzling opportunities, so I do want to acknowledge the validity of what you said.

However, I want to also add a word of caution, because I think what is emerging with the information superhighway could really be the emergence of a new class-based system. Who is going to have access to these new "pit stops" on the information superhighway? Who is even going to have the "techno car" to drive on it?

I believe that many old people are not going to have the little PCs in their home, nor are the working class. I think it is a very class-based access system even in terms of the hardware in their homes.

So I would hope that while we use every tool available in this new information superhighway, which I am quite bullish on, I hope we can still turn to the good old YWCA and what they are doing with outreach to particularly minority populations—and remember our public health infrastructure, which needs to be kept as in tune as the information superhighway system.

Dr. LEE. Yes, I agree with that. It is interesting that in the House—and I do not know if anyone has taken the leadership in the Senate—but in the House, Congressman Markey has made this point very strongly as he has been chairing a subcommittee that is looking at this issue, that it has got to be equal access. That is a critically important issue with respect to the highway, but also the point you make about community-based health education is very important. And also in the plan, I should just add, we do have a school-based health education initiative, and we really have to start in the schools if we are going to make real progress in some of these prevention areas.

Senator MIKULSKI. Senator Boxer?

Senator BOXER. Thank you, Madam Chair.

I want to say to this panel that this has been really interesting for us, and particularly the discussion about the Genome Project and how that is going to change things for us, and it is a plus as well as a minus—it is one of those confusing situations—because when we know we have a propensity, we can get wonderful preventive treatment for it, and yet we might be denied insurance. So if we do not have universal coverage, it is going to be a terrible problem, and I think that was a very important contribution today.

I want to ask some questions about breast cancer, and I first want to say that although my questions are not going to seem pleasant, and I may seem angry about it, it is not directed at anyone on the panel; it is a frustration that I have about the way this issue is proceeding at this time.

I am not a scientist, as I said at the outset, but I have to tell you that after all the years that women were told by their physicians that it is crucial that at age 40, you get a baseline mammogram, and if you have no risk factors, every other year; if you have risk factors, every year, basically forever—and now to have this tremendous confusion hit is very disturbing to me.

Now, am I incorrect, Dr. Broder, when I ask you this—is it not so that breast cancer is the leading cause of death for women between the ages of 40 and 44?

Dr. BRODER. It most certainly is—from any cause.

Senator BOXER. So we have the leading cause of death among women ages 40 to 44, and yet we have a situation where—and I know there is a split in the community—some very prestigious organizations and institutes, certainly the National Cancer Institute, are now stating that it is not necessary to get a mammogram.

In the President's plan, does is call for a baseline at age 40; is that included?

Dr. BRODER. Please, with respect, we are not saying that mammography should not be done.

Senator BOXER. No; I am talking about inclusion in the basic benefit package. That is what I am talking about.

Dr. BRODER. If you are speaking on the issue of the benefit package——

Senator BOXER. That is what I am talking about.

Dr. BRODER. —I have no standing to comment on that, and I would turn to Dr. Lee.

Senator BOXER. All right. In the basic benefit package, we have no baseline at age 40, or do we, Dr. Lee?

Dr. LEE. As I understand it, we do not have a baseline at age 40. That would begin at age 50.

Senator BOXER. All right. Now, I understand—and again, correct me if I am wrong, whoever is the expert—that approximately 46,000 women die every year from breast cancer; is that correct, Dr. Broder?

Dr. BRODER. That is absolutely correct.

Senator BOXER. All right. And I understand that 80 percent of breast cancer does occur in women over the age of 50; is that correct?

Dr. BRODER. That is correct. Approximately 80 percent of breast cancer occurs over the age of 50, and approximately 85 percent of the deaths occur over the age of 50.

Senator BOXER. OK. But every, single year, we will have, as my statistics show, about 36,400 women in their 40's who will be diagnosed with breast cancer, because as I look at it, we have 182,000 new cases of breast cancer, and 20 percent of that is 36,400.

Dr. BRODER. That is approximately correct.

Senator BOXER. OK. So we have 36,000 women in their 40's who will get breast cancer. Now, what are the best tools that we have at our disposal to fight breast cancer? Can you name those, Dr. Broder?

Dr. LEE. Once it is diagnosed?

Senator BOXER. What are the best tools we have to prevent breast cancer and to treat breast cancer once it is diagnosed?

Dr. BRODER. I believe this has to be taken in the context of the total picture first, and I will respond to the specifics of your question. First, I would briefly preface it by saying that what we need to do, at least the NCI's level, is to provide the facts as best we know them, and our philosophy is informed either by randomized clinical trials or a scientific consensus——

Senator BOXER. OK. What are the best tools we have to detect breast cancer? Can you just answer that?

Dr. BRODER. OK. On the basis of clinical trials and on the basis of scientific consensus, for women over the age of 50, the best early detection tool that we have is mammography coupled with a clinical breast exam. I believe those two must be linked together. Although some in the community have separated them, most of the clinical trials data do not permit an absolute division between those two. So I believe those two tools have to be used together. Now, that would allow for——

Senator BOXER. OK. When a women is age 48, that is not true?

Dr. BRODER. What we can say is on the basis of the available randomized clinical trials that we have, between the ages of 40 and 50, when all of the data are looked at together in composite, screening mammography has not resulted in a reduction in the death rate. There is extreme polarization and controversy in the

scientific community. Many individuals of good will, of comparable intellect, have looked at the data and have come to opposing conclusions.

Senator BOXER. I understand.

Dr. BRODER. So therefore, between the ages of 40 and 50, we as a scientific agency feel that we cannot give a general statement that screening mammography will reduce the death rate in that population. That is our scientific——

Senator BOXER. Do we know why that is the case? I mean, what is the rationale for that? What happens at age 50 that suddenly, this becomes as good too, but at age 47 or 48 or 49, it is not a good tool?

Dr. BRODER. You are asking an extremely important question, and we as a science-based agency—science, in the best sense of that term—can only give the facts. What we can say is that all parties—all parties—agree that mammography has a better positive predictive value and has been able to achieve a more dramatic effect in women over 50, even those who advocate between 40 and 50 as a screening basis. And the reason for this in part is due to many factors, or at least people believe it is due to many factors.

In part, the breasts of younger women are radiographically dense, not just by palpation—you cannot necessarily say palpation is the issue—but radiographically are dense. There are some studies that have suggested, and there are some published results that there may be as high as a 40 percent false-negative rate. What that means is that the mammography may be actually missing a tumor. In some women, there is a small number of women in whom the tumor is actually palpable and yet still not detectable on screening mammography.

So it is possible—possible—that there is an inherent false-negative rate of whatever one agrees to the actual rate, and that that in fact is diluting the value of the screening in that age population. Another explanation——

Senator BOXER. My time is running out, and I want to ask you this.

Dr. BRODER. I had one more important explanation.

Senator BOXER. Yes, go ahead.

Dr. BRODER. That is that it is possible—it is possible—that in some younger women, the disease metasticizes on a microscopic basis early. Very few women—very few women—in our culture die today of their primary cancer. That is not what kills them. Primary local control is not the issue. It is the fact that in some women, there has been microscopic spread at a very early phase. That microscopic spread might—might—in younger women occur at an extremely early phase. So the issue is not necessarily whether mammography picks up the tumor, but is what treatment occurs afterwards.

So the other fact that is frequently lost is that mammography is only a prelude to what has to happen. Mammography alone, as a single thing, has never saved any woman's life. It is what happens after the mammography or the detection, by whatever means.

So I think part of the discussion also has to focus on are we giving adjuvant therapy and all the other things, and it may be that that is an additional confounding factor in that age population.

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Senator BOXER. If I might just continue for another minute, Madam Chair.

Senator MIKULSKI. I believe the Senator from California is onto a very important stream of questioning, and would allow her to go ahead.

Senator BOXER. Thank you. Just another minute or two would be very helpful.

Senator MIKULSKI. Absolutely.

Senator BOXER. I do not think anyone has ever said that mammography stops cancer. It detects cancer. We all know that. And I really appreciate your explanation, because if it fails to detect it—if it may fail to detect it is what you said—in women in their forties, and you have given us reasons for it, that is more understandable. But as you said, it is not completely clear. And as I understand it—and correct me if I am wrong—there are 21 other national medical organizations that do not agree with this conclusion, is that correct, including the National Cancer——

Dr. BRODER. The list may be even higher.

Senator BOXER. OK.

Dr. BRODER. But the American College for Physicians, which in this country represents most of the primary internists who are available on this, certainly agrees with the our fact statement. And in addition if I might very briefly alert the chair that one of the most distinguished schools of public health, the School of Hygiene and Public Health at Johns Hopkins University, one of our best institutions in the world on public health issues, currently, the acting chair of the Department of Health Policy and Management—in acting capacity, the chair is Sam Shapiro, who pioneered mammography, pioneered the original HIP study, so there would probably not have been mammography without that individual in 1963—I urge the chair, I urge the committee to seek testimony, publicly or privately, from Sam Shapiro so that at least they are informed on his views on these issues, because I think there are very few sources that have more authority on this point.

So I strongly urge that that be done if the committee would agree, at least publicly or privately.

Senator MIKULSKI. The committee will contact Dr. Shapiro for those comments, and we thank you for that recommendation.

Senator Boxer?

Senator BOXER. If I could conclude, then, I would just say this to Dr. Lee and to Dr. Blumenthal. I really applaud what the President is doing in this plan. Look, we are talking about a benefit package here which we have never had before. We have other health proposals that have no benefit package, that are going to be decided in some back room, behind a closed door. And just frankly, we as women legislators can tell you that for some strange reason, we have not been included in those closed doors, and I am so glad to see Dr. Blumenthal playing such a key role with you, Dr. Lee. This is really important to us.

Dr. BLUMENTHAL. Thank you, Senator.

Senator BOXER. It is just that you are hit with almost a culture shock when you have worked so hard to tell your friends, to tell your employees, to tell every woman you know over 40 to take the precaution. And what I would urge the President's team here, as

well as those members of Congress, all of us, who will vote on this, is that I am not willing to throw out a diagnostic tool unless there is clear scientific evidence—clear scientific evidence—that it just does not save lives. I do not think we have that scientific evidence yet. Even Dr. Broder says there may be a longer list than 21 organizations who do not agree. And after all these years of struggling to get 40 percent of women to have mammograms, I am certainly not ready to say throw that baby out because we do not have the tools yet, and until we do, that is one that we do have.

I thank you very much for being here.

Dr. BRODER. Senator, if I might just briefly say we want to empower women. Where there is controversy—the facts are going to be there; they are going to hear the controversy no matter what we do——

Senator BOXER. Right. Well, we are women who are empowered. [Applause.]

Senator MIKULSKI. Please, no demonstrations.

Senator BOXER. And what we are saying to you is we want to make sure that we are getting unequivocal science before we throw out a tool that we have fought so hard to get, so hard to get. And when you have 46,000 women a year dying—50,000 tragically died in the Vietnam War, and we have 46,000 each and every year—we are empowered, and we are going to take your advice and your information, and we are going to act in what is the best interest of the women in this country and, frankly, the men of this country, who need us around.

Dr. BRODER. But we need to empower individual women so that they hear the unvarnished facts and therefore are not just getting a pronouncement. When we make a pronouncement, the women of this country have the right to ask on what basis did you make such a pronouncement. And where we have doubts, we do not know what else we can do except share them. I am very comfortable—I believe women in this country are exceptionally intelligent. They want the facts, and then they want to make the decision that they need to make. But what I am afraid can happen is that if a pronouncement comes out, and the facts in both directions are not presented, if it is simply distilled as a final solution, and there is no controversy, there is no debate, then we might simplify a solution.

Our whole theme in what we are trying to do is to develop a system where individual women—over the age of 50, which is an unbelievably important component, there is no controversy—between 40 and 50, we think that there is a customization, an individualization, that might need to be made, and we want the women to know the facts. And with respect—and I hope my words are not misinterpreted—it would be patronizing for us as an institution to issue a pronouncement without at the same timing giving all the facts as best we can. It might be inappropriate for us to attempt to bring closure on an issue where there is intense polarization without sharing with people that there is that polarization.

I do not know how else to do this.

Dr. BLUMENTHAL. Madam Chairman, may I have a moment?

Senator MIKULSKI. Yes.

We want to acknowledge that Senator Murray has joined us. We are having a very robust conversation on issues related to breast

cancer, and I believe also many elements of the conversation would be included in Pap smear and ovarian cancer early detection.

Dr. Blumenthal?

Dr. BLUMENTHAL. Yes, Madam Chairman and Senator Boxer, I want to assure you that Dr. Broder, Dr. Lee and myself are all extremely concerned about breast cancer and dedicated to eradicating death from this disease.

I think what Dr. Broder has presented is the best scientific evidence. There is a study that tells us that if you look between 40 and 50 at 1,000 women, that 700 will have had some unnecessary procedure, or biopsy, during this age period because the mammography is not that accurate during this decade; that it will have missed 7 women with the disease, and that it will have detected 15. As a mass screening procedure, the evidence does not support it during this decade, and it shocks us and it alarms us and saddens us.

I can assure you that this administration and this Department will not rest until we develop more sensitive imaging techniques and other molecular methods to detect breast cancer in women of all ages, but particularly between 40 and 50. We share your concern, and we share your sense of urgency. And I think that if we can image missiles in distant skies 20,000 miles away, surely we should be able to image small lumps in women's breasts right in front of us. And we are committed; I know Dr. Broder has initiatives underway, and we are going to intensify those efforts so that we have better methods, more sensitive methods, for this decade.

Dr. BRODER. We would be pleased to brief you privately on all of the new imaging and all of the new molecular approaches, magnetic resonance imaging, and other things that we are doing on a research basis, a number of issues related to digital mammography and other technologies. We would be pleased to do that at any time of your choosing.

Dr. LEE. Senator Boxer, the other thing that I think is very important is the breast cancer gene and the research that is going on there. As that moves forward—and Sam may be able to tell us what the status of that is now—we would then have a method of really identifying those women whom we would need to follow in a way that could detect the disease early and really do the job that we all want to do.

Senator MIKULSKI. Senator Boxer, and before we move on to Senator Feinstein, let me say this. First, this is why I raised the issue of a breast cancer strategy and why we know that there has to be an array of approaches to dealing with this killer, dealing with prevention, of which early detection is only one tool, and the care to be provided as well as the ability to exercise personal responsibility, but personal responsibility within scientific advice. And that is why we want to move on this as quickly as we can.

We congratulate the administration on holding the breast cancer summit at NIH, in which it sought a variety of viewpoints from scientists to advocates to actually people who themselves had cancer. So we appreciate that.

We also appreciate what is in the benefit package, because for so long, we had to fight even for recognition of the validity of this. But now, on this brink of having national health insurance reform

passed and a single benefit package, we are looking at what the content really should be, and to that extent, this subcommittee will be asking CBO to get the cost estimates of what it would be to screen women under the age of 50 every 2 years and over the age of 50 every year, so that as we look forward to what our legislative strategy is, we will have the benefit, colleagues, of knowing what the cost will be as well as what the science is.

But of course, we believe it is not only what is the cost of the technique, but what is the cost when you have cancer to a family, what are the costs both financially and emotionally because of the lack of early detection.

So I think we have really had an excellent conversation, and we want to turn to Senator Feinstein, and then we welcome, of course, Senator Murray.

Senator FEINSTEIN. Thank you, Madam Chairman.

Dr. Lee, Dr. Broder, Dr. Blumenthal, thank you. I have been listening to this with some interest, and I am sure you know that to begin mammography at age 50 is at variance with the screening guidelines of the American Cancer Society and about 21 other organizations.

The American Cancer Society makes a recommendation, and that is that mammography be available on a routine basis to women over the age of 50 on an annual basis, with no cost-sharing, and for women ages 40 to 49, every one to 2 years, based on risk and other factors discussed between the woman and her physician.

Doesn't that seem to be a strong way of handling this, or a good way of handling this?

Dr. BRODER. Are you directing that question to me?

Senator FEINSTEIN. To whomever wants to answer it.

Dr. LEE. I would say, Senator Feinstein, as we looked at that, the Cancer Institute, of course, looked at the scientific evidence. They were not addressing whether this should be a benefit or not a benefit. That ultimately, of course, is a political decision.

We looked at the——

Senator FEINSTEIN. Well, let me just say I do not think these decisions should be made on a political basis. I think they ought to be made on the basis of scientific evidence and merit.

Dr. LEE. You use the best science that you have, but ultimately, the elected officials make the decision.

Senator FEINSTEIN. Well, that may be a problem.

Dr. LEE. You will make the decision. We will give you the best advice that we can give based on the science as we see it.

Senator FEINSTEIN. I will tell you that I think all health care will fail if elected officials make the decisions about whom should have what and when. I really do not believe that that should be the decision of elected officials. It should be the decision of the medical community and the consumer community.

But let me just ask you to reflect on that recommendation by the American Cancer Society. Why is that not a valid option? Why is that not a selectable alternative?

Dr. LEE. The reason is that, as Susan Blumenthal pointed out, the evidence with respect to women age 40 to 49 does not support current evidence that we have been able to review and analyze; it does not support that as a wise policy decision for screening—not

for diagnostic use, not for medically appropriate or necessary when a physician thinks it is appropriate for an individual patient, but as a screening procedure for women who have no symptoms and for whom there is no reason to suspect a breast cancer. It is a very different thing with a diagnostic mammogram, which of course is included in every plan.

Senator FEINSTEIN. Are you saying that for a women in her early forties that if she were to have a mammogram once or twice during that period, it would have no screening value, it would not turn up anything?

Dr. LEE. The evidence that Dr. Blumenthal presented and that Dr. Broder indicated the Cancer Institute had reviewed, is first that there is no change that we can detect in mortality for those women who have been screened versus those who have not been screened in that age period.

Second, as Dr. Blumenthal pointed out, the number of cases that are diagnosed—what was it, Susan, 15—could you repeat those figures again?

Dr. BLUMENTHAL. Yes, that out of 1,000 women, for over a decade, 700 unnecessary procedures, including biopsies, would occur; 15 cases would be detected, and 7 would be missed per 1,000 women.

Senator FEINSTEIN. Well, what is wrong with detecting 15 cases?

Dr. BLUMENTHAL. There is nothing wrong with that. It is not——

Senator FEINSTEIN. I mean, why wouldn't a plan want to do that?

Dr. LEE. Well, if you had a method that would do that in a way where you do not, then, subject 700 women to unnecessary procedures, where you do not find any difference in the mortality in the women who are screened and not screened——

Senator FEINSTEIN. What about morbidity, Dr. Lee?

Dr. LEE. I mean just looking at the data—now, the thing that we believe because of these problems is that we have to put a very intensive effort, as Sam said, on developing these better methods. Clearly if we can screen women between 40 and 49 in a way that produces the kind of results we get over 50, we would do it tomorrow. It is just that this area is a very gray area.

Ten years ago, among a number of groups, there was an agreement that we should screen women from 40 to 50, and I think that is part of the dilemma we face now. As the evidence has come forward over the years, and as there have been some of these controlled trials, they have not shown the kind of evidence we hoped they would show. We hoped they would show clear-cut, substantial benefit from screening mammography in women this age. And that is the reason why, in the benefit package, it was strictly based on that evidence that we made those decisions. And there is a clear difference between the cancer society and the decision we reached on that question.

Senator FEINSTEIN. Clearly. Let me move on for a moment. With respect to the benefit package, would it provide for the use of drugs like taxol, for a woman to get on a taxol program?

Dr. LEE. If a drug is approved by the FDA, if it is an FDA-approved drug, it is included. A drug can be used for off-label use if it is approved in three compendia, or if there is significant literature that would support the use of that.

Now, with respect to taxol, that is currently being used in clinical trials, Sam, on the breast cancer clinical trial?

Dr. BRODER. Taxol is currently approved for ovarian cancer, but it will also——

Dr. LEE. It has not been approved for breast cancer, then.

Dr. BRODER. Not as an indication; we are doing that. But it certainly has activity in a number of diseases including breast cancer, and we feel, based on our clinical trials results, that it is a very active drug in breast cancer.

Senator FEINSTEIN. Well, would this be an approved drug in the President's plan, and what would its cost-sharing, if any, be?

Dr. LEE. It would be approved currently for the treatment of ovarian cancer.

Senator FEINSTEIN. All right.

Dr. LEE. In the high-cost plan, there is a deductible of $250, and then there would be a cost-sharing—I think it is 20 percent of the cost of the drug.

For the low-cost plan, it is $5 for the drug, and there is no cost-sharing. So the cost-sharing arrangements are different in the different plans.

For the treatment of breast cancer, when the trials are completed, it would then be possible to make a judgment, but it would not be approved for use until those trials were completed and we knew whether it was effective or whether the side effects, which are not inconsequential, would merit the use in women for breast cancer.

Senator FEINSTEIN. Thank you. One of my increasing concerns is women who are pregnant who are addicted and who are giving birth to children who are either drug or alcohol-addicted and central nervous system-damaged, and therefore a real problem for all of their lives. How does the President's plan approach this problem by way of prevention, by way of treatment of a pregnant woman, and then subsequently, the treatment for the child who is addicted?

As you know, the cost of just moving a child out of an infant preemie unit can run $250,000. I have visited hospitals, and I have seen eight to twelve addicted children at any given time, at Martin Luther King, Jr. Hospital in Los Angeles, San Francisco General in San Francisco. I think it is going to be a major problem of tomorrow.

So if you could comment on how the plan—currently, a woman is not eligible for Medicaid if she is pregnant and addicted. She cannot use Medicaid for medical services to get herself off of her addiction.

Dr. BLUMENTHAL. All prenatal care will be covered in the plan without cost-sharing, and of course, all medical services for the baby following delivery would be covered as well.

Senator FEINSTEIN. Regardless of—if she is addicted, she would still have access to care?

Dr. BLUMENTHAL. For the child and for herself, yes, absolutely.

Senator FEINSTEIN. For herself and the child.

Dr. BLUMENTHAL. And then in terms of the mental health benefit, in terms of substance abuse treatment, there are both outpatient and inpatient services available. It is a flexible spectrum of

benefits to include divert outpatient kinds of treatment plans, residential treatments, and so forth. And there would be unlimited medical management in terms of any condition that she would have, substance abuse or mental illness, and an additional 30 outpatient visits per year for psychotherapy in terms of treatment of her illness.

Senator FEINSTEIN. And the baby?

Dr. BLUMENTHAL. All of the medical services associated with the baby's care would be covered, depending on the cost-sharing of that plan, whether it was the low cost-sharing or the high cost-sharing.

Dr. LEE. Senator Feinstein, we also will be continuing the current substance abuse and mental health benefits in the Public Health Service. Those would continue in Title III, and we would provide increased funding for outreach and enabling services, in other words, to reach out to that pregnant addicted mother to get her into care, because many of them do not access care early, as you know.

The objective would be to reach out and get all of those women into care as early as possible. So it is a combination of what is in the plan, the benefit packages, everybody covered, plus continued public health drug treatment programs, which you are very familiar with because of your experience in California.

Dr. BLUMENTHAL. And a third aspect, too, is more investment in research in terms of prevention, being able to motivate women with addictions to get the care they need to prevent unnecessary medical consequences to their children.

Dr. LEE. There is also very important research at the National Institute of Drug Abuse regarding antagonist potential of things like cocaine, so that we have some opportunities, we think, coming out of that basic research that may bear fruit in the reasonably near future.

Senator FEINSTEIN. Thank you very much.

Thank you, Madam Chairman.

Senator MIKULSKI. Thank you, Dr. Lee.

Members can submit additional questions. The chair has been advised that sometime in the next 15 or 20 minutes we might have a vote.

I want to welcome Senator Kay Bailey Hutchinson to the hearing. As you know, we are attempting to proceed on a bipartisan basis with the hearing. Senator Hutchinson, you are welcome, and we look forward to your comments and any questions to the panel, and then we will turn to Senator Murray, and then the panel will be excused.

Senator HUTCHINSON. Thank you, Madam Chairman.

First, I want to thank you for calling this hearing. I do not support the President's health care plan, but I do support the need for whatever plan passes to have women's health care issues covered fully.

I have known what Senator Mikulski's views are on what areas should be covered in any health care plan for women, and I am here because I want all of the Senators to know that we will have a united front on women's health care issues.

It is of great concern to me that there does not seem to be an understanding in this country that many times, a woman's main

doctor is her ob-gyn doctor; many of her basic tests are done by her ob-gyn doctor. I think it is most important that we realize that that is her primary care physician in many instances.

So I guess the good news is we have educated women to the need for Pap smears and mammograms, so they do go to an ob-gyn, but the bad news is they also are sometimes using them for their primary care, and we have got to make sure that we cover it.

I would like to ask a couple of questions about, first of all, in all of the health care plans that you are seeing come across—although I know of course you are supporting the President's plan—but in any health care plan, do you feel that the research into women's health care, which I think everyone admits is now coming to the forefront but has been lagging behind, and therefore we are behind in breast cancer research and in ovarian cancer research in emphasis, now if we are looking at any kind of controls or any kind of mandates, are our women's health care issues going to suffer in the research category?

Dr. LEE. Certainly not in the President's plan. There is an effort both to expand funding for NIH research in the plan, $400 million. There are also efforts to support clinical trials in the academic medical centers or other centers where approved clinical trials would be undertaken in a way that I think would give clarity with respect to the support for those trials. The plan would support the basic costs. There would be a fund set up which would support in the teaching hospital or in the academic health center additional costs that would be associated with those trials. And then, of course, the sponsors of the trials provide the additional funds necessary for the research part of the trial, but not for the basic care.

So I think we have in the plan a mechanism that would provide more adequate support for clinical trials, at the same time that we are, of course, increasing support for research at NIH, and a significant amount of that would be related to women's issues, that is, a prevention initiative at NIH in terms of the research.

Dr. BLUMENTHAL. Additionally, the Office of Women's Health within the Public Health Service, which has recently been strengthened, is determined to weave a women's health perspective into all of the agencies of the Public Health Service. And there already is a major focus at NIH, CDC, FDA, HRSA, ACPUR. So that really, we are bringing together the various perspectives of the Public Health Service and their agencies to solve these major public health problems that affect women today.

Senator HUTCHINSON. Do you see an increase in the emphasis in your area on women's health care problems just in the last few years? Do you see more of a percentage of our budget going for women's health care research?

Dr. BLUMENTHAL. Absolutely. I think, thanks to the dedicated work of Senator Mikulski and others in this room today and other members of Congress, working with the scientists and with public pressure, that we have finally begun to see a change in the way women's health is being approached.

We have seen the establishment of offices of research in women's health at the NIH, we have seen a focus within each of the agencies and a number of initiatives that have really been burgeoning over the past several years. And we are determined to really re-

dress the inequities that have been exposed in 1990 to assure that women are included in clinical trials, to assure that women have access to quality health care services, and that women have the education that they need to get the services that will improve their health.

Senator FEINSTEIN. How could you assure that if we did have limits on overall health care spending, or if we had any kind of price controls on drugs, that private sector research or public sector research into ovarian cancer, breast cancer, would not be restricted when you are looking at the priorities in spending of primary care or acute care versus the research dollars that are, by their very nature, more long-term?

Dr. LEE. We certainly do not believe that in the President's plan, there is any proposal for price controls on drugs. With respect to controlling the overall expenditures, we clearly have to find some mechanism to do that. The percentage of our income, the amount of money flowing in, we think we provide already about 4 percent more of the gross domestic product in health care. That will increase at least another 3 percent under the President's plan. So it is not going to decrease the amount of money. It is going to slow the rate of increase over time.

With covering prescription drugs, of course, you provide access of patients to those modern advances. I think we have the best pharmaceutical and the best biotechnology industries in the world. We see with this kind of market very significant incentives. We will be investing through NIH funds in basic and clinical trials.

I think there is some disagreement about what are the future income streams. We met recently with the pharmaceutical manufacturers, and they have provided an analysis which suggests that the income streams for those manufacturers will be somewhat diminished, and I think you need to get the facts directly from them as opposed to my recollection of that presentation.

So there is a difference of view about that, but we believe that with access to care, with the kinds of policies that we have had—and Congress, of course, has been a principal partner in this, in the support of NIH—that the research advances will continue. We see some areas where that is going to come very rapidly; the Genome Project is an example.

So we do not believe that we will see a drying up of the research, although I think we all share a concern that this has got to be maintained as a vital part of the whole system.

Senator HUTCHINSON. I know my time is almost up, but let me just ask you one quick question because it is of great concern to me, and it is on a more general basis. This study that just came out recently that said that mammograms were not really necessary or as useful in women under 50—I do not understand it. I mean, I hear what they are saying, and I am certain that they did studies, but it just does not compute.

Senator MIKULSKI. Senator, the reason we are smiling is not at the serious nature of your question nor your confusion. Every single one of us has articulated the same frustration and the fact that we, too, are confused. So that is why you see us smiling; it is a smile of sisterly support.

Senator HUTCHINSON. Well, did you get a good answer? Let me just say, if all of you have covered it, that I just think it sends the wrong message to the women who are now educated to take care of themselves to have this brought up. So if you can enlighten me quickly, I am nonplussed, as I guess all of us are.

Dr. LEE. Sam, do you want to comment on the NCI analysis? Let me just say very quickly that we spent the last hour, actually, discussing this issue. Senator Boxer brought up the same issue very, very forcefully and in very much the same context. I think we have heard very clearly the concerns of the members of this committee on that particular issue.

There are two issues. One is what should be in the benefit package in whatever health reform is enacted for screening, not for diagnosis; that is very different. Diagnostic mammography is included for women when it is medically necessary and appropriate. For screening, we have felt—and this was an analysis that we did, and the Cancer Institute did a separate analysis and did not make recommendations to those of us who were on the task force in dealing with this issue—we felt that weighing the evidence, there was not sufficient evidence to warrant covering screening mammography for two reasons. One, the mortality rate did not appear to be reduced in women who had had mammograms and those who did not. Second, the number of adverse events—I mean, you do have to radiate a woman's breast to do a mammography; that poses a certain risk—there were 15 cases detected and seven cases missed in a large series that was analyzed. Seven hundred women underwent procedures that they would not have had to undergo. So that there are serious consequences for screening mammography, and in weighing that evidence, we made a judgment that this was a benefit that we did not think was wise to include at this time.

We believe that it is absolutely essential that we develop the technologies and move forward with better methods to have screening methods that are applicable, because breast cancer is very prevalent in women of that age group, and more women die of breast cancer than of any other cause. So that it is a major problem. It is just that we do not believe the technology that is currently available is sufficiently good to warrant including. We hope that very soon, we will have methods that will be very effective, and certainly, they would be included.

That was the basis for the discussion, and we would be very glad to meet with you and bring some other people in to sit down with you personally and review that in much more detail.

Dr. BRODER. Senator Hutchinson, the key point is that for all women, whatever their age group, we believe that we cannot prevent them from knowing the facts, and that they have to be brought into the loop so that they have informed choices. We want to increase their degree of freedom, if you will, and that women of any age group have to participate with the scientific and medical community, and they need to be given the facts.

Mammography may have a role and certainly has a proven role for women over the age of 50, but between 40 and 50, there is a significant debate, and there might be a different calculus, a different algorithm that one would use if a women has a first-degree relative who has breast cancer or who has some other high risk fac-

tor than if she does not have a known risk factor. Those are issues that need to be brought to the table. And also, clinical breast exam needs to be part of any discussion of mammography. What we are saying is that we have to enter an era where we cannot simply give pronouncements, and where there is doubt in the scientific community, the woman has to be part of that, and that we cannot simplify a message where it cannot be simplified.

So that the issue of mammography over 50 has a very large consensus. Between 40 and 50, there is an enormous debate. And what we are saying is that we need to provide the facts to women. We are not at the NCI for or against mammography between 40 and 50. What we want to do is bring the woman in as a partner, as an informed, intelligent partner, so that she can make a decision about what is best for her.

Senator HUTCHINSON. Well, I certainly think that we need to have the coverage as we learn and as the technology improves, and saying that we will not cover screening between those ages I do not think is a good result.

So I am willing and want to learn more about the scientific evidence and the risk factor, which certainly is important, but I want to make sure that we are covered as we are in the process of finding this information and that someone is not covered if they do fall into a risk category.

Senator MIKULSKI. Senator Hutchinson, we thank you for those questions. I think we are all in agreement with the same line of questions and with the same outcomes that we seek, and of course, we hope that we will be able to meet in a bipartisan way on our strategy as this moves ahead.

We will have a third panel of providers, particularly the ob-gyns and the American Medical Association, if you could either stay or come back for that panel, where we could even pursue this more rigorously.

Senator HUTCHINSON. Thank you.

Senator MIKULSKI. Senator Murray?

Senator MURRAY. Thank you, Madam Chairman, and I especially thank you for holding this extremely important hearing.

Senator MIKULSKI. It is historic.

Senator MURRAY. It is historic, and it is well-needed, and I am glad to see that it is bipartisan. And I do not want to beat a dead horse, but I have to add my comments to the ones Senator Hutchinson and Senator Feinstein and Senator Boxer have already reiterated about mammograms.

You know, we were told that you have got to do this every year beginning when you are 35, and now they change it on us. So what you are seeing is a very deep frustration among women. We are responsible people. We do not want to contribute to the national debt and do things that are not necessarily going to be worthwhile. But I think that that is part of why we have a problem today. Women in the past have said, "Do not spend the money on me; take care of everybody else first." That is part of our makeup, and as a result of that, we do not have the research today that we really deserve and ought to have, and I think what you are hearing is a strong commitment from all of us for that research, but we do not want to lose out in the process.

I think it is very concerning to us that you are not saying to women, "When you are in your teens, when you are in your twenties, here is what you can do to lessen your chance of breast cancer." The only thing we know is have a test so you know if you have it. It is a deep frustration and I think one that we have got to address to millions of women in this country.

I do want to ask one question about that and then move on to something else. What are the adverse effects of a mammogram?

Dr. LEE. Well, one would be the radiation. That is one thing which can have an adverse effect.

Senator MURRAY. Over time?

Dr. LEE. Yes, and especially if you have multiple mammograms. Second would be if a mammogram detects a lesion that results in a procedure, there could be potentially adverse consequences of that procedure—going through the stress of that procedure and the emotional consequences. Those would be several of the potential adverse consequences of mammography where it does not produce——

Senator MURRAY. You mean a false positive reading?

Dr. LEE. Yes, right.

Dr. BLUMENTHAL. You then have a biopsy.

Dr. LEE. You then have a biopsy, a procedure, and sometimes multiple procedures in order to determine whether——

Senator MIKULSKI. But that went to the sloppy mammogram standards that we had to fight tooth and nail to get, and also——

Dr. LEE. We agree with you about the standards and the need to improve the standards, and that is a process that is ongoing, but that has certainly been a problem in the past.

Senator MURRAY. Well, I will let that go at this point because I know we are going to hear about it again, but I do want to bring up one other topic. It is one that concerns me deeply. As a matter of fact, I had a very close friend die this last weekend of ovarian cancer—a woman in her forties with an 8-year-old son. I had another acquaintance die a week ago of ovarian cancer. And I started asking questions and was astounded to find how little we know about ovarian cancer. The fact is that two out of three women, once diagnosed, will die very shortly.

I want to know what is being done in terms of research on ovarian cancer and what type of screening or research is being done on what we can do when we are younger so that we do not have ovarian cancer when we are in our forties.

Dr. BRODER. Ovarian cancer is one of the surpassingly important research objectives of the National Cancer Institute. Approximately 12,500 women each year will die of ovarian cancer. The median age for ovarian cancer is approximately 63. That means half or over half are younger. The disease certainly can occur in younger women, but predominantly it is a disease that occurs in the fifties and the sixties. It is an important disease.

There are a number of issues related to early diagnosis, and among the most exciting developments—which I cannot give you a promissory note today because you will ask me to redeem it, and I may not be able to—is the identification of certain genetic factors, one of them recently identified from Johns Hopkins University in the pursuit of a totally different cancer, but there is a new gene

that has been discovered that in part predisposes to ovarian as well as endometrial as well as colon cancer. There is also another gene called BRCA-1 which predisposes to breast cancer in some women and ovarian cancer in others.

So there is a genetic approach. Francis Collins, the head of the Human Genome Project, has told me that he will have the gene identified in 6 months. I cannot promise that he will be accurate, but if he does, that will provide a new tool to address the specific point you are asking about. Women would be able to have a genetic test in part to help them identify whether they are at additional risk.

We have a very large randomized controlled trial involving women and men, but asking different questions, of course, in the different genders, called our PLCO trial, and we are asking whether the utilization of a test called CA-125, as well as transvaginal ultrasound, we are asking whether women who get those procedures will have a better outcome than women who are just followed by usual care.

This is a long-term commitment study. It is one of our highest priorities. And we will have the study done, and we will answer those questions. Unfortunately, it will take time, and it will probably take many years before we have the answer. But that gives you a flavor of the kind of research agendas that we are doing.

In addition, we at the National Cancer Institute have been the primary driving force for new therapeutic interventions. Among the most recently new interventions is taxol. Again, I am sorry to keep coming back to Johns Hopkins University——

Senator MIKULSKI. You can. Keep pouring it on, and keep on funding them. We want it.

Dr. BRODER. —I really am not being paid to do this—but they actually helped us with the earliest taxol trials, and we are learning.

Senator MURRAY. Has taxol shown to be effective at all?

Dr. BRODER. Yes, ma'am, it most certainly has. There is no question that it will alleviate suffering in certain subsets of women for whom there is no other option. Press accounts to the contrary, we would be very happy to brief you on our clinical trials.

Now, in general, it cannot be used as a single agent, but particularly for women who have advanced ovarian cancer, taxol has activity, and we have recent data that it can have durable complete responses. I do not want to convey to you the impression it is a miracle drug, but what I am saying is I stand here to tell you that it is certainly an advance in ovarian cancer in combination chemotherapy.

Senator MURRAY. And I am delighted about the gene research, and I have heard from Fred Hutchinson in Seattle about that as well. But barring that, I realize that it is years away, what is the early detection for ovarian cancer today, that is, what screening methods?

Dr. BRODER. There are no proven screening technologies that we can say are proven to work. There are two tests that some doctors use called the CA-125 test, which is like a blood test, and there is also transvaginal ultrasound. Those are two techniques that some doctors feel are helpful in early detection.

Dr. LEE. And there is the trial that Sam mentioned that is ongoing to determine their value.

Senator MURRAY. And are these covered under the health care plan?

Dr. LEE. The plan would not cover experimental procedures unless they were being performed as part of an approved trial; then the plan would pay for the routine care, and the investigation part of that would be paid for by the sponsors of the investigation.

Senator MURRAY. So if you were a woman, and they suspected that you had ovarian cancer, and they did one of the screening methods that you have just described, it would not be covered in the plan?

Dr. BRODER. Yes, it would be covered.

Dr. LEE. No, that is not a screening test. For diagnostic purposes, it would be covered. As a screening test, we do not have a method yet for screening. The purpose of this is to determine its value in that regard. It would be covered—if a woman came in and saw a physician, and the physician ordered that test, that would be covered.

Senator MURRAY. Whether or not the test was positive or negative?

Dr. LEE. Absolutely.

Senator MURRAY. OK. Thank you.

Dr. BRODER. There can be no reimbursement system—I said I have no standing to get involved in this, but I will anyway—we would denounce any reimbursement system which required the test to be positive before we are reimbursed. The test has to be paid for whether it is positive or negative. I did not clear that with Phil Lee.

Senator HUTCHINSON. I am really glad you clarified that, though, because I was wondering the exact same thing.

Dr. BRODER. If you are going to pay for the test, it must be no matter what the outcome is.

Dr. BLUMENTHAL. And I want to underscore, too, coming back to the clinical preventive services, that it is such a step forward in terms of improving women's health, and really, the health of all Americans, because at no cost, we are having a set of early detection and health-promoting interventions that will go a long way, I think, to improving the health of all Americans. And again, most people do not realize, because this is the first national conversation we have had about health care, that a lot of these services have never been covered before, and now they are free.

Senator MIKULSKI. That is right, Dr. Blumenthal, and that point that I want to make to my colleagues is that this is a hearing primarily on the benefit package; it is not the only hearing that we are going to hold on women's health and proceed in this bipartisan way.

My colleagues will find it interesting that I chair the Subcommittee on Aging, and being the chairman, I have changed the title to "Aging and Life Cycle Issues," which meant essentially women's health. We will be having other hearings on this, and I believe what we are really going to look forward to is when the breast cancer strategy is done—and we urge it now to be moved along with a definite time for bringing to closure the commentary and so on—

I believe my colleagues would like very much to hear the comprehensive administration strategy on breast cancer, and then we will be talking about those other issues. And we will be pursuing this more as we go along today, for those who can stay.

We did not have the opportunity in the time available to go into such important issues affecting women as the issue of women's health, the issue of pregnancy-related services, and we know that there are others that we will be discussing. We will be meeting among ourselves, also, on how we will proceed on health insurance reform.

We really thank you for this, and we know that this is the first time we have been talking about a single comprehensive benefit package that has the right elements. Now, whether it has the right timing, and issues related to that, I think we need to flesh out even more.

But we also—and this is speaking for the women Senators and really for all women—if we are confused, think how American women are, because we are data-obsessed on this. We read about it all the time. This has been one of our advocacy issues. And we believed that screening would begin at 40 with the baseline study, and then to mark our way through from 40 all the way through 80. That is why we worked so hard on providing Pap smears and mammograms and other detection devices earlier.

So now, when we talk about this dialogue—and Dr. Broder, we believe there has to be an ongoing dialogue between the provider and the woman—but right now, we have been so schooled in believing that you need a mammogram starting at age 40 and have it every year, and we have advocated that, and now to have a benefit package that recommends something else is confusing and disturbing. So we look forward to further conversations with you on the science, the detection, and also, I will be asking CBO on the affordability issue that I will share with my colleagues.

So we thank you for really a very excellent panel, and we look forward to other conversations.

Dr. LEE. We appreciate it very much, and I think you can be sure that we listened very, very carefully to what was said to us today.

Dr. BLUMENTHAL. And we care very deeply. Thank you.

Senator MIKULSKI. Thank you very much.

I will now call the second panel, which includes Jeannie Rosoff, Betty Dooley, Susan Troyan, and Scott Daniels. This panel will provide us with data on the type of coverage most women receive today.

We would like to turn first to Scott Daniels of the Family Research Council, who has conducted a survey in this area. Then we will move to The Guttmacher Institute and Jeannie Rosoff; to Betty Dooley from the Women's Research and Education Institute, the bipartisan group established in the House; and then to Dr. Troyan from Beth Israel.

Mr. Daniels?

STATEMENTS OF SCOTT DANIELS, FAMILY RESEARCH COUNCIL, WASHINGTON, DC; JEANNIE ROSOFF, PRESIDENT, THE ALAN GUTTMACHER INSTITUTE, WASHINGTON, DC; BETTY DOOLEY, EXECUTIVE DIRECTOR, WOMEN'S RESEARCH AND EDUCATION INSTITUTE, WASHINGTON, DC; AND DR. SUSAN L. TROYAN, BETH ISRAEL HOSPITAL, BOSTON, MA

Mr. DANIELS. Thank you, Senator Mikulski. I recognize your leadership on women's health issues. You do not know this, but I gained respect for you a few years ago when you referred earlier to those meetings at NIH that established the Office of Women's Health. I was serving at that time as executive assistant to the assistant secretary for health, Jim Mason, and I remember that September 10th morning very well.

Senator MIKULSKI. When Connie Morella and Pat Schroeder and I showed up.

Mr. DANIELS. Yes. And to use your words, the discussions that day were "robust," and so have been subsequent hearings on this topic that you have held, and I really expect nothing less than that this morning.

I also know, Senator Mikulski, first-hand the importance of the hearing that you are holding this morning because my wife Connie is the mother of two children, Andrew Scott, age 4, and Melissa Christine, age 7, and she is a breast cancer survivor.

Although we live with a great deal of uncertainty about the future, because of early diagnosis, which was the subject of the discussion of the first panel, we have been given much greater hope, and I generally wish the same for other women in similar situations.

I am here this morning representing The Family Research Council, a Washington-based research organization that analyzes the impact of national policy on the family. We do have a number of concerns about the role of the family in health care reform, especially the President's plan, but this morning I am here only to address the question of whether or not every American should be forced by Federal law to pay for abortion on demand through Government-mandated premiums and other taxes.

In advocating abortion coverage in the standard health benefits package, pro-abortion activities have recently rallied behind the rhetoric of preserving the status quo. Ironically, however, their argument for the status quo has been undermined by one of abortion's strongest proponents, and that is Pamela Maraldo, who said that "the inclusion of reproductive health services, including all abortion services, in a basic benefit package will truly constitute a defining moment for reproductive rights in America." Then she went on to add that the inclusion of abortion is equivalent to the decision in Roe v. Wade. I think Ms. Maraldo has helped to set the record straight on this.

It is our view at The Family Research Council that the President's plan in actuality is an extreme position on this question. It would mandate that all Americans and institutions pay for abortion irrespective of their deeply-held and conscientious beliefs about elective abortion. By contrast, the true status quo is that coverage of elective abortion in private health insurance be voluntary, not mandatory.

Now, at this point, I would like to briefly examine abortion coverage in private insurance in terms of its prescriptive and its descriptive elements. We have arrived at these conclusions on the basis of an informal survey that we conducted last late August and September, and let me just say at this point that at that time, there were generalizations being made, and we did not feel it necessary to be scientifically rigorous. I really did about the same thing that you would do, Senator, which is, in facing a complicated question, you would go home and consult with a wide array, you would try to make it as representative as you possibly could, and then you would try to make some reasonable judgment on the basis of those conversations, and we did something about the same in that regard. And of course, at that time, there were not really rigorous scientific studies available.

But what we did learn from that experience is that there are a number of problems in this area. When we look at the descriptive issue, that is, what is or are the current practices among insurance companies, there are a number of problems that really surface methodologically, and I think it really leads one to conclude that this is an area in which the subjectivity of the controls are very much at issue.

There are, of course, hundreds of insurance companies comprised of different types of plans, subject to employer desires and the like, and this means, for instance, that a large insurance company may offer abortion coverage in certain policies but exclude it from others that they offer.

Now, furthermore, the question is complicated by the definition of abortion itself. Does the term "abortion" in the survey questions refer to cases where the life of the mother is threatened or to elective services? And if you were to ask an insurer just, "Do you cover abortion?" without further clarification, you can imagine the kinds of responses you would get.

But here is something that I think is not well-recognized by the studies that I have had the privilege to look at—and I have not had a chance to study AGI's unpublished study at this point, but would be happy to comment if that would be helpful to the subcommittee, at some later date—and that is this. What we found—we talked to insurance companies, benefit consultants, commissioners of departments, and policy holders, because we wanted to find out how many are denied these services, and could we get some sense of what was going on—what we found, particularly in talking to insurance companies, is that they are scared to death to answer that question because of the economic implications of it. That is to say if I were to represent, say, a pro-life organization, and I asked that question, the company is not going to be very likely forthcoming on some of that information because there are such things as economic boycotts, etc.

By contrast, if I were representing as a pollster a pro-abortion group, I would be sort of concerned as well about the implications. So these affect the biases in the responses, and I think that that has to be brought to bear, and they only underscore the extreme difficulty that there is methodologically in this area. And these were some of the problems I found that were not, in my view, adequately addressed in some of the previous informal surveys.

So that led us to our concerns about statements that there is a vast majority of insurers that provide, and we came to the conclusion that, really, no such generalization can be made.

But second, and fundamentally, and really to underscore a point that you made this morning if I understood you correctly, which was that we need to talk about what should be included, which is really a normative question, and I think that is where the question really lies, because even if we could come up with a reasonable description of what goes on in insurance companies, this does not mean necessarily that one would overthrow the present voluntary system for some mandatory system that the President is proposing.

And health care reform really turns on the prescriptive question alone. Rather than ask the question what is done, we should ask what ought to be done. Many Americans, myself included, think that there are good reasons not to mandate abortion coverage in private insurance. The issue is whether or not to make abortion on demand a mandatory service which Americans must pay for. And here are some consequences of such a policy.

First, institutions which have a religious and moral aversion to elective abortion, but which have a compassionate desire to cover the general public and the uninsured, would be forced to include abortion on demand in their health plans. For this reason, the existing "conscience clause" for providers in the President's bill is inadequate.

Second, another consequence that would come up is that forced payment for abortion is highly subjective as evidenced by the recent public opinion polls.

Third, abortion will sabotage needed reforms in the current health care delivery system that benefit American families.

Congress has consistently recognized the divisive nature of abortion coverage in private insurance in passing Federal laws. Over the past decade, the Hyde Amendment, the 1978 Pregnancy Discrimination Act, the Title XII HMO Amendments to the Omnibus Act of 1988, and the Education Amendments to the 1988 Civil Rights Restoration Act have all ensured that employers and insurers have the option whether or not to cover abortion.

So clearly in its oversight of the private insurance market, Congress has obviously been able to discern that abortion on demand is not a medical procedure for which Americans should be forced to pay.

To make abortion part of the common comprehensive benefit package as the President intends to do, and so require policyholders to finance abortions regardless of their moral sensitivities, is not merely unprecedented, Senator, but goes beyond any semblance of tolerance.

Thank you very much.

[The prepared statement of Mr. Daniels may be found in the appendix.]

Senator MIKULSKI. Thank you very much, Mr. Daniels, and if you wish at another time to comment on any of the surveys and comments, you are most welcome to do so.

Mr. DANIELS. Thank you.

Senator MIKULSKI. Now we would like to turn to Jeanne Rosoff, the president of The Alan Guttmacher Institute, who will report on

the findings of their new national landmark survey on the coverage of family planning and reproductive health services that Mr. Daniels alluded to.

I want to bring out something, though. We will not be debating each other. We are presenting our individual viewpoints and will proceed from there.

Ms. Rosoff, please go ahead.

Ms. ROSOFF. Thank you for having us.

I must say that I share—or at least I shared—Mr. Daniels' concerning about the reporting of coverage of reproductive health services under private health insurance. It is a very, very complicated issue. There are many, many companies in the business, and there is a lot of anecdotal information about what my policy covers or my sister-in-law's policy covers, which does not yield much information on the subject, which is why we in fact undertook the study which I will begin to report on today.

Let me make the point that normally, we would not advance these results before they are published and peer-reviewed and in a peer review journal. Unfortunately, the timetable of this hearing required us to be here and give you the information that we have. We do have fairly voluminous appendices to the methodology which I would like to submit to the committee and otherwise just summarize the information.

Senator MIKULSKI. We want to acknowledge that, and we want to acknowledge what Mr. Daniels said, too, that it had been unpublished. We were anxious to move along in our hearing to get out what needed to be included in the national debate, and not wait for the perfect methodology and the perfect responses. So if good is good enough for Mr. Daniels' survey, and good is good enough for the Alan Guttmacher study.

Ms. ROSOFF. Let me first say that we surveyed reproductive health services, and we mean this very broadly to include maternity care, preconception care, contraception, contraceptive sterilization, counseling of all types, sexually transmitted disease, and infertility services, because all of these services will be needed by women and sometimes by men during the course of their lives, and all these services are related to each other. Access to family planning has implications for good birth outcome; access to sexually transmitted disease screening has a relationship to fertility. So all of these services are related to each other. They are all important. And as I have said, in many cases, they involve men as well as women.

Unfortunately, for the purposes of this hearing, we can only report on a few of the findings. This was a 12-page questionnaire, a very dense questionnaire, which addressed 25 topics related to reproductive health. We are just going to give a few of them today.

The universe was quite comprehensive. We selected the 100 largest insurance companies in the country that cover about 68 percent of all the applicable insurance market. We surveyed a great variety of types of insurance policies, including something which is not usually covered, which are the self-insured policies by employers.

We surveyed all Blue Cross/Blue Shields in the country, and we also surveyed a very large samples of HMOs, which covered 106 HMOs that have more than 100,000 enrollees, and then we did a

sample of 107 smaller HMOs to get good geographical coverage for the country.

We also got unusually good response rates. Anyone who is in this business knows that getting information from doctors is very difficult. Getting information from insurance companies is also very difficult. We were very gratified that we had a 58 percent response rate from all the large and small insurance companies, 53 percent of the Blue Cross/Blue Shield, and 50 percent of all the HMOs surveyed. So we feel quite confident that we have captured as much of the market as is humanly possible, and in this we had the help of a very eminent advisory panel, as well as a lot of informal help from insurance companies.

What I am going to deal with is only the services which relate to the achievement of pregnancy, if you will, family planning services, contraception, contraceptive sterilization, and abortion—and, excuse me, preconceptional counseling.

We started with an assumption which I think is shared by anybody who knows the insurance companies that, given the history of insurance in this country, that it is quite likely that surgery in general, hospitalization and surgery, are likely to be covered. This is because insurance started as a way of protecting people against rare and strange medical occurrences on which you could protect yourself by belonging to a group, and the actuarial likelihood of your getting this particular disease or condition was relatively small, which made it commercially possible.

I think our perception of what good medicine is now has changed, with much more emphasis on prevention, and therefore what I am going to talk about in terms of the insurance companies I think represents the past and I think gives some indication of where we want to go in the future.

As I said, we had anticipated that there would be coverage of sterilization and abortion in insurance companies because of the general bias toward covering of surgery. We were surprised at the strength of this finding, and we were even more surprised and distressed at, in fact, the lack of attention to prevention and the very poor coverage of contraceptive services in general.

Let me start with the surgical services. We asked three questions. We asked do you cover services that are medically necessary appropriate; do you cover them with additional conditions, which means the doctor would have to certify something unusual to make these services accessible; and not covered at all. We found that 85 percent of insurance companies in fact covered contraceptive sterilization; about two-thirds covered abortion with no specific recommendations; and another 20 percent did cover, but only for strict medical reasons.

Finally, when we got to contraception, we found that only 15 percent of insurance companies covered all main methods of contraceptive for women at this point, which are the IUD, the oral contraceptives, Norplant, the diaphragm, and Depoprovera injections.

There was some difference between types of insurance companies. Commercial insurers had poor coverage. Blue Cross/Blue Shield was somewhat better, and you will see this on the charts, and HMOs in fact had the best coverage.

Since my time is running out—and I will be glad to answer questions, and we have a lot of details on this——

Senator MIKULSKI. Please complete your testimony. In terms of your written remarks, I believe you have about two more pages to go.

Ms. ROSOFF. Yes.

Senator MIKULSKI. Why don't you just go ahead and go through that?

Ms. ROSOFF. Thank you. I think as far as what we see is startling is in fact the lack of coverage of preventive health services. And this is where I think the Clinton plan is a first cut, very important improvement not only for the health of women in general, but I think the health of the country.

The Clinton plan, as you know, does cover family planning services under a category called "Family Planning Services and Pregnancy-Related Care." We were somewhat distressed because I think we view prenatal care and family planning services as in fact preventive health care which would be covered under the preventive health package and therefore not subject to copayments. As it is, in fact, family planning services would be the only service in the plan that would be required to have a copay.

We are very concerned because insurance companies, even those that cover drugs and devices, tend not to cover contraceptive drugs or devices. In fact, the plan is very explicit on this. I think it is not enough to rely on general coverage of prescription drugs as the Clinton plan does. I think you do have to specify contraceptive drugs and devices; otherwise, experience in terms of insurance shows that they will not be covered.

So these are the recommendations we would make for the plan. Let me go back for one moment to the question of the surgical services, abortion and sterilization. These are not exotic or rare services used by very few women. In their lifetimes, 46 percent of all women will have at least one abortion. Unfortunately, some of them will have to take that decision more than once. This is not a small number. Forty-eight percent of women will become sterilized either for physical reasons or for contraceptive reasons. This is half of all women in the United States.

Senator MIKULSKI. Are you talking about hysterectomies?

Ms. ROSOFF. No. I am talking about sterilization which is undergone for contraceptive purposes, that is, women who have had their two or three children or whatever number of children they decided to have, and either they or their husbands decide to be sterilized. Sterilization is the most common method of contraception for women over 30. That always comes as a surprise to people when they hear it, but this is not a rare procedure, and neither is abortion a rare procedure.

So that I think the coverage of the insurance companies in terms of surgery is very much in the mainstream of medical care, not only in terms of the needs of patients, but I think in what doctors do in their private practice. What is apparent in this coverage of insurance companies is in fact the lack of coverage of contraception, and I could not urge more the committee to really pay attention to this very, very serious lack of coverage, and even some of the failure, I think, of the Clinton plan. I think all of us are concerned,

for example, about the extent of abortion, and we all would like to lower its incidence, and to have plans and policies which indirectly favor the coverage of surgical procedures rather than preventive measures seems to be turning things on its ear.

Thank you very much.

[The prepared statement of Ms. Rosoff may be found in the appendix.]

Senator MIKULSKI. Thank you, Dr. Rosoff. We will come back to questions after everyone has completed.

Now we would like to turn to Betty Dooley, who is the executive director of the Women's Research and Education Institute, a research and education institute that originally was founded to help the Congresswomen's Caucus have solid research on a variety of issues, whether it was Social Security coverage or health insurance coverage.

Ms. Dooley, we would like to turn to you for your testimony.

Ms. DOOLEY. Thank you, Senator Mikulski.

You are overly modest in not saying that you were a founding member of that Caucus in the House 17 years ago; it has been quite a while.

I want to thank you, for women, for me personally, and for everybody, for holding this very important hearing today. And it is encouraging to see some bipartisan support here this morning for issues that we care very much about.

My remarks today are taken from a recent study done by the Women's Research and Education Institute entitled, "Women's Health Insurance Costs and Experiences." And Senator Mikulski, if it could be entered into the record, if you would consider that, we would appreciate it. You will find it user-friendly, and you will find the data absolutely reliable.

Senator MIKULSKI. Without objection, so ordered.

Ms. DOOLEY. Thank you, Senator.

This study was made possible by a grant from the Kaiser Family Foundation, and we relied on data from the National Medical Expenditure Survey. The analysis was conducted by Lewin-VHI, a nationally known consulting firm. Our report is the first of its kind to examine the costs to women for reproductive and preventive services.

It shows that women are especially vulnerable to high health care costs, and women usually have less income than men. It demonstrates that low-income women, unemployed women and uninsured women are at great disadvantage in our present health care system. And here are some of the highlights of the report.

Women of childbearing age, those 15 to 44, are twice as likely as men in this age to use preventive services. We know that these preventive services—tests like Pap smears and mammograms—though routine can save lives. And this has been discussed today. Yet many women in our society lack coverage for reproductive care, and here are some of these—the uninsured; those who have insurance that excludes these services; or those with high deductibles and coinsurance that in effect act as barriers to care.

The result is higher out-of-pocket cost. In this age group, these people pay 68 percent more out of pocket than men do, and these expenses come after taxes have been paid.

We are very troubled to find that one-fourth of poor women have out-of-pocket expenses that exceed 10 percent of their income.

This report underscores the importance of reproductive and preventive service being covered in health care reform. One telling example. In 1993, a woman with a pregnancy-related stay in a hospital paid on average out of pocket over $1,000. And the high out-of-pocket expenses are just part of the story. Keep in mind that health care costs discourage women from getting needed care. Sixty percent of black and Hispanic women do not get preventive services, and a majority of uninsured women do not get preventive care. And the lower the income, the less likely a woman is to receive preventive care. Fifty-five percent of women below the poverty line do not in fact get preventive care.

In summary, women have much to gain from health care reform. The President's Health Security Act would dramatically improve women's access to preventive and reproductive services. But the Catch-22 with this plan and others may be in the benefit package and the formulas in place for out-of-pocket cost. We hear a lot of discussion in this country about the bottom line, and here is another bottom line. Women have the children that perpetuate our race. If it were not for that fact, women during these years would have approximately the same health care costs out-of-pocket for health care than men have.

We urge all of you people in Congress to remember this when you tackle reform.

One final comment. We heard Congresswoman Schroeder testify before Congressman Waxman's committee, urging that women have as much spent on health care as men do. Well, in fact, I think our report shows, Senator Mikulski that women perhaps need more spent on their health care than men.

Thank you very much.

Senator MIKULSKI. I think you mean more in certain areas, particularly those that are pregnancy-related.

Ms. DOOLEY. Preventive services especially.

Senator MIKULSKI. We will come back to what you mean by preventive services.

[The prepared statement of Ms. Dooley may be found in the appendix.]

Senator MIKULSKI. Dr. Troyan, we would like to welcome you. We know that you are a breast cancer surgeon at Beth Israel Hospital in Boston, and you are the director of research at the Faulkner Breast Center; you are an instructor in surgery at Harvard Medical School and have studied this issue related to coverage and also what the compelling needs are. We look forward to your testimony.

Dr. TROYAN. Thank you. Thank you very much for asking me to come and speak today about an area that is very important to me. Not only do I spend all my time at work dealing with breast cancer, in that my entire practice is dedicated to the detection and the treatment of breast cancer, but on top of that, my away time from the hospital is also spent on breast cancer, as I am board member of the Massachusetts Breast Cancer Coalition, on the board of the National Breast Cancer Coalition, and cochair of the Access Task

Force. So what this committee is doing is very important to me, and I appreciate the ability to be here and speak to you.

This year in the United States, as we have been hearing this morning, more than 180,000 women will be diagnosed with breast cancer, and more than 46,000 women will die of this disease. It is estimated now that one in eight women living today will be diagnosed with breast cancer sometime during her lifetime. It is the most common cancer among women and the second leading cancer killer.

We know how to prevent nearly 90 percent of lung cancers, which are the leading cancer killer of women, but we have no idea how to prevent breast cancer. There is no method of preventing it, because we have no idea what causes it.

Well, sometimes, when we do not know how to prevent a disease, we can look at the risk factors that are associated with that disease and try to avoid them. The three major risk factors associated with breast cancer are age, a prior diagnosis of breast cancer, and a family history of breast cancer in a first-degree family member. None of these we can avoid.

And the other important fact is that of women who develop breast cancer, nearly 80 percent of them do not fall into one of these major risk categories. So the truth is we do not know how to define who is at risk for breast cancer.

This morning we heard a little bit about the breast cancer gene, but we believe that gene will probably only be responsible for 5 to 10 percent of breast cancers which are diagnosed. That still leaves approximately 90 to 95 percent of women in the unknown risk category. So in truth, we must realize that all women are at risk, and we must educate women that anyone with breasts is at risk for breast cancer.

Until we are able to find out the cause of breast cancer, and until we are able to prevent it, it is very important that we be able to detect breast cancer as early as possible, when the treatment methods are more likely to be effective.

Currently, there are three methods for screening of breast cancer. There is breast self-exam; there is clinical breast exam by a health care practitioner; and there is mammography. Although breast self-exam is widely promoted, studies evaluating this method have failed to show any increase in survival between women who perform breast self-exam and women who do not. So it has not been shown to be effective.

Clinical breast exam is effective when coupled with mammography. Mammography is the single best tool we have for screening for breast cancer. Studies have shown that regular screening mammography can decrease the mortality from breast cancer by about 30 percent. This reduction in the death rate from breast cancer is far greater than any of our treatment methods, including chemotherapy, hormone therapy, and bone marrow transplant.

Mammography is a specialized x-ray of the breast. It works by showing a different in the density of the breast tissue. Fat has a low density on mammogram, while glandular has a very high, white density. Both benign lumps and cancers show up as high-density or white on mammogram. So what you are really trying to do is look at a difference between these.

When we are young, we have a lot of glandular tissue within our breasts, and therefore we have a big, white, dense background, and it is difficult to see things like benign lumps and cancers against that white background because they are also white. As we age, our breasts become less glandular, more fatty, and therefore become blacker on mammogram, and you can begin to pick up the small white densities of cancer. This is why mammography is more sensitive as we get older.

Now, the time line for these changes in our breasts and the amount that our breasts change varies remarkably from woman to woman. There are some women in their early thirties who have great breasts for mammography, and there are some women in their sixties who still have very dense breasts. It is a gradual change.

Consensus guidelines for screening were agreed upon by many institutions in the 1980's, so that consistent recommendations could be made by different practitioners, decreasing the confusion and allowing for greater education. These were agreed upon recognizing that we do not have all the scientific data necessary to make definitive statements. These guidelines for mammography have been and continue to be: the first screening mammogram by the age of 40; mammograms every one to 2 years between 40 and 50; and yearly mammograms over the age of 50.

The results of screening studies are now coming in. There is clearly a decrease in mortality from breast cancer in women screened over the age of 50. Studies have not yet shown a decrease in mortality for women under the age of 50. Experts are still divided as to whether mammographic screening is not effective in this age group, or whether these results merely reflect the fact that most of these studies were not designed to look at this age group separately.

The Canadian study, which is the only study which was designed to look at this age group separately, has been criticized for being too short in follow-up and also having flaws in the design.

There is clearly as yet no definitive scientific evidence that can tell us that mammography is or is not effective in reducing the death rate from breast cancer in women under the age of 50. With such controversy, I would caution against changing any guidelines for screening at this time.

At present, screening mammography coupled with clinical breast exam are our only tools for the earlier detection of breast cancer. Women must have access to quality screening mammograms. If health care reform does not cover the current screening guidelines, women in many States may have a decrease in coverage. These are women who up until now have managed in some way to continue insurance coverage or health care plans which cover mammography. This is often mandated by State laws in the areas where it is covered.

In spite of the seemingly endless pre-existing conditions used to exclude them for coverage, some women have managed to get their mammograms covered, and the current plan, Clinton's health care plan, would not cover for some of these interval screening. What it would do, which is absolutely essential, is give universal coverage to all women. There is no doubt that more women will be

screened once health care reform comes through if this plan is enacted in its current form. And it is very important that we assure universal coverage as well as an outreach to undeserved women to bring them into the health care system and screening.

Clearly, we need to realize mammography is far from optimal. As we attempt to solve these screening issues, we must look for better detection methods. Even in women over the age of 50, regular screening mammograms will only reduce the risk of death, not eliminate it.

In some women, the body's immune system is able to kill of the cells that may escape during the period of time that breast cancer is growing, before we are able to detect it; but in others, the cells will have already spread before we detect it, and therefore some women will still die—in fact, too many women still die of breast cancer. We need to develop a biochemical test where blood or urine samples can be screened and detect these early changes. We need treatments that can intervene and reverse the process as well as improve breast imaging to locate these cancers once the women have screened positive.

Thank you.

[The prepared statement of Dr. Troyan may be found in the appendix.]

Senator MIKULSKI. Thank you very much, Dr. Troyan, and I thank all of the panelists.

Ms. Dooley, I want to ask about your survey and this whole issue of preventive services. In the survey, when they talk about "preventive services," what are you talk about? Are you talking about preventive contraceptive services or other preventive services?

Ms. DOOLEY. Both, Senator Mikulski.

Senator MIKULSKI. But what did the survey cover, Ms. Dooley?

Ms. DOOLEY. It covered both.

Senator MIKULSKI. OK.

Ms. DOOLEY. I think the most basic thing is that we have in this country health care for everybody, men and women and their families, and that as you have said before, we have a benefit package that is not one class of health care for one group of people and another for another group of people, and another for another.

If you would like me to read the preventive services from——

Senator MIKULSKI. What page are they on, Ms. Dooley?

Ms. DOOLEY. Page 5 of the technical appendix at the very end.

Senator MIKULSKI. Why don't you read that? I think that is very important because I do not believe these really vary depending on one's philosophy or faith preference.

Ms. DOOLEY. This study identified preventive services primarily through the reason for a medical visit—that is, general checkups, vision exams, immunizations, maternity care for normal pregnancies, and if no specific diagnosis were indicated for the visit.

We restricted preventive services to medical provider visits and outpatient visits. Outpatient maternity care for normal pregnancies was included as both a reproductive and preventive services.

Due to the self-reporting nature of the data, it appears that most routine gynecological examinations have been classified as preventive services because very few were specifically identified through the V72.3 Code under "Other Reproductive Services."

This data is from the NMES study.

Senator MIKULSKI. So therefore, what is being advocated in the Clinton plan, which is universal coverage, and universal coverage for routine physicals is one of the keystones to preventive care because this is meant to kind of, every year or every other year, get a sense of where you are, what you need to do in the area of self-help—perhaps weight reduction, the issue of smoking and others.

Ms. DOOLEY. Yes.

Senator MIKULSKI. So probably one of the most important issues related to prevention is universal coverage so that every man, woman and child would be able to have these routine physicals and then, according to their provider's recommendation, whatever else they need; is that correct?

Ms. DOOLEY. Yes.

Senator MIKULSKI. Dr. Troyan, as a practicing physician, although I know surgery is your specialty—and we will ask this of the next panel—is it your observation—and this is anecdotal—that most women seek their primary care, if you will, that physical, as part of going in for a yearly Pap smear, or if they believe they are pregnant, that their ob-gyn for most women is really their primary care physician—most women who are postadolescent?

Dr. TROYAN. Actually, even adolescents nowadays. But as you start to get into women in their late teens, twenties, and into their thirties, the primary care practitioner for many women is their ob-gyn, or wherever they go for their birth control or family planning.

Senator MIKULSKI. But that is where also, as part of that, they are getting a blood workup and all those things that might detect diabetes or concerns that could lead to lung cancer, other problems like lifestyle habits?

Dr. TROYAN. Are you asking whether they get that when they go to the ob-gyn?

Senator MIKULSKI. Well, when they go to the ob-gyn, they go for gyn services, but the gyn, at least it has been my experience, wants to know a little bit more about me, and if I have not had a recent evaluation by my primary care physician, she wants to do the blood work and so on. I have a propensity to high blood sugar, so we have got to watch that. That is the kind of thing I am talking about. So that what we are talking about is that when women go to the ob-gyn, they are also getting some of these other evaluations and preventive services; am I right?

Dr. TROYAN. Some are, some are not. I think it really depends upon the obstetrician-gynecologist.

Senator MIKULSKI. So that is part of that big education that Dr. Lee talked about. You see, we feel there has been so much where everybody has said the women need to be educated—and we do not minimize that; we believe that all of this self-help and self-referral has happened because of massive public education—but we are concerned that the provider community is not as on top of their game as the women themselves.

Do you have any thoughts on, one, if you think that is true, and number two, how that could be corrected?

Dr. TROYAN. Well, I think that as we have learned more in medicine, we have begun to specialize. And once you start getting spe-

cialization, the people within their field know a lot about their own field, but they may not be as aware of other parts of the field.

I would say that physicians who go into ob-gyn did not do it so they could be primary care practitioners, although they end up being the primary person for many women, as in the women are not going to primary care practitioners, and they are only going to their ob-gyn. But they were not trained to be there and to do that. They do very well as far as ob-gyn is concerned, but they may not be very good primary care practitioners.

I try to encourage the women who see me in my practice to have a primary care practitioner because there should be someone trained to do that who is up on all the different areas and can help advise her and educate her.

Senator MIKULSKI. Of course, I think every provider should be up on the total person.

Dr. TROYAN. Absolutely.

Senator MIKULSKI. If you are down, and you are smoking, and maybe you are drinking too much, maybe it is because you need family counseling.

Dr. TROYAN. Yes. I absolutely agree with that.

Senator MIKULSKI. And when you come in, I presume there is going to be a basic evaluation related to blood work and so on, and not just say, "Well, I do not know if you have diabetes; I am only interested if you are going to have a baby or not." So that is another whole hearing that we will have in the future after we get the benefit package on the education of all providers.

I would like to turn to Mr. Daniels. At The Family Research Council, I believe your post is health and also ethics?

Mr. DANIELS. Ethics and health policy; that is correct.

Senator MIKULSKI. Yes. And I am sure you have been looking at a variety of the issues related to the benefit package. I know you have commented on your work related to abortion or pregnancy terminating services. Have you also looked at the issues related to voluntary family planning and contraception, and do you have any comments on that?

Mr. DANIELS. We have looked at a couple of the areas. We do have problems—policy differences—on the promotion of school-based clinics. Principally, we feel like there are some very strange phrases in the bill. One phrase refer to reducing barriers to implementation. Now, coming out of the Public Health Service and having read some of the literature over the course of the years, "barriers" can oftentimes refer to and do refer to parental consent and parental involvement and decisionmaking of the children that they are rearing. So I am very suspicious about those kinds of phrases, and you will understand from the background from which we come that that is going to raise serious problems.

We also have looked at and have problems with areas of the health education that are built into the standard benefit package. They are very vague, and I can imagine all sorts of things coming out of that. And again, there will be value differences—I fully recognize that. Coming out of philosophy, I recognize dissent as being one of the highest forms of compliment. So I think we would have some disagreements on that.

Those would be the two principal areas that we have looked at. We frankly do not think school-based clinics are effective. I have brought one of our reports this morning that reviews the literature on do school-based clinics work, and we have found—and we are happy to provide that to other members of the panel, to your staff, anybody on the committee—contrary to these clinics working or being a panacea to the sexual behavior of adolescents, they tend to, by the scientific reviews, increase them slightly. So I think that there is some reasonable ground for doubt there in that regard.

So those are the areas we are looking at.

Senator MIKULSKI. Thank you, Mr. Daniels. I think we would all agree that the best family planning for adolescents is abstinence.

Mr. DANIELS. Yes.

Senator MIKULSKI. But on the issue of school-based clinics, apart from the issue related to teenage pregnancy, what is your view or that of your Research Council on school-based clinics being a tool for primary care and prevention? We find that so many of our young boys and girls have undetected medical situations, vision problems; among African American males, the tendency to high blood pressure even at a very early age—all of those kinds of things that really, because their families do not have a medical home, and in some instances, they themselves do not have a home at all, their families have no medical home. The only permanent place in their lives is the school. So we wonder what your views are on school-based and community-based clinics as part of the benefit package.

Mr. DANIELS. Primary care.

Senator MIKULSKI. Yes, so that the clinic would be that medical home for kids.

Mr. DANIELS. Well, at this time, I have only been onboard for about 9 or 10 months, and looking at all of health care reform and all its ramifications, we have focused only on the two subjects that I have mentioned. That is not to say we have precluded looking into some of these other areas, but at this time, these are the two, in addition to other facets of the 1,364-page bill, and I am principally involved in that.

Senator MIKULSKI. We understand. Thank you, and we look forward to looking at that pamphlet and having further conversation.

Mr. DANIELS. Thank you.

Senator MIKULSKI. I would like to now go to Ms. Rosoff at The Alan Guttmacher Institute. Why do you believe that so few voluntary family planning services are covered—and I say "voluntary," because in a democratic society, I think we would not want anything coercive in this area.

Ms. ROSOFF. I really think it is due to historical reasons and the way I think we have looked at medicine in general. I think insurance was supposed to help you to be cured of disease, and I think we have now looked at health in a very different way, and the name of the game is to try to avoid getting the disease in the first place, both because it avoids pain and suffering, but it also avoids great cost to society.

So I think what you have there is an almost historical lag in the insurance company and the way it has looked at the practice of medicine. I think there is also a lag as to the concerns of women

in general. These are obviously services which are very important to women. And I think when you look at these policies, in most cases, when it comes to contraception, at least you have a feeling that the reason why it is not covered is because nobody thought about it. I mean, it is the worst form of benign neglect. It is not because people made a business decision and said, "I am going to cover this, but I am not going to cover that." It is simply that nobody really thought about it very much, and somehow, in some cubicle somewhere, somebody made a decision, and it is covered or not.

There is no rhyme or reason why certain plans will cover diaphragms but not IUDs, IUDs but not Norplant, contraceptive sterilization but not Norplant, which is a temporary form of, if you will, sterilization. I mean, you can find no logic behind those policies, which is why I think the Clinton plan is a great improvement even though, as I said, I think there are some shortcomings in the plan in the coverage of contraceptive services.

Senator MIKULSKI. Would you want to restate what you believe are the shortcomings of the Clinton plan in the area of family planning services?

Ms. ROSOFF. I think the Clinton plan makes an arbitrary difference between certain kinds of reproductive health services like mammograms, like Pap smears, like detection of sexually transmitted disease, and treats these as preventive services, but does not treat prenatal care or family planning as preventive services. These are distinctions without differences.

Now, why that happened—there were lots of people working on the plan, and I suppose somebody made some arbitrary decision on this. But it does not really make much sense, and in terms of policy, I think it is time we looked at all of the services which are related to reproduction for women and for men as a whole and as a package. It is true that 20 years ago, even the expression "reproductive health services" did not exist, so we cannot fault anyone, I think, for failing on some of these aspects. But I think it is important that we look at all of these services in relation to each other.

If the 17 or 18-year-old girl contracts a sexually transmitted disease that she may not even be aware of because she may not have symptoms, she may have difficulty having children later on in life. We cannot say that, well, she is only 17, and she has this disease, and now let us think of her at 75. I think we have to look at this as an entire package, and I think to make an arbitrary distinction between certain preventive services and others in relation to reproduction is artificial and not helpful. And I think this can probably be cured very easily by members of Congress.

Senator MIKULSKI. On the issue of prenatal services, this then is subject to copayments and deductibles.

Ms. ROSOFF. All preventive services plus prenatal care are not subject to deductibles or copayment. For some reason, family planning is. I have no explanation for it. I said in the anteroom that the preparation of the Clinton plan was like dealing with a centipede; you never knew which of the 100 arms or legs you were talking to. And I am not sure that——

Senator MIKULSKI. I think members of The Family Research Council would agree, and this is a methodology you would both agree on.

Ms. ROSOFF. And I think that there are decisions which were made which I think are not fatal and can be remedied by congressional scrutiny.

Senator MIKULSKI. Well, in terms of the family planning services, they are covered in HMOs, and yet not in large group plans. This is where it seems to be uneven.

Ms. ROSOFF. Again I think it goes back to the history. The HMOs were created to provide in fact a different kind of medicine with a strong emphasis on prevention. So it is not accidental that you will find better coverage. But let me say that even in HMOs, only 40 percent of HMOs provide all medically approved methods of family planning. And again, there is no rhyme or reason for this. Our own HMO in New York, for example, covers abortion, does not cover sterilization, covers oral contraceptives only if medically necessary—I mean, if you are sick, and that is the reason you are getting oral contraceptives. There is no even plan, even in HMOs.

There is another point which is very important in HMOs, and unfortunately, we cannot give you data on this. It has to do with the whole question of managed care and how quickly you can get access to care. If you have to call ahead to make an appointment to see a primary care physician before you can get birth control, then you are likely to be pregnant before you make your way to a provider. So the whole question of access to care, even if it is paid for under the HMO, is a particular area of problem, but unfortunately, I do not have data that I can report on this at this particular point. The study does cover this question of access in some detail, but I cannot tell you——

Senator MIKULSKI. If I might say, Ms. Rosoff, what is so surprising to me about your survey—I expected wide differences in the coverage of abortion because of the socially provocative nature that it is in our society, and good people of conscience can differ on this issue, and we acknowledge that—in terms of the family planning services, and the precision in which they decide to do it or not, I find really surprising.

Also I find that the more chemically intrusive it is, the more likely you are to get it, whereas those mechanisms where, again, we are talking about voluntary, we are talking about adults—the use of a diaphragm takes a visit, some teaching, perhaps some ongoing monitoring and advice—and that is not covered, although one would say Norplant is certainly chemically intrusive.

I am actually bewildered by that.

Ms. ROSOFF. So were we.

Senator MIKULSKI. Mr. Daniels, did you want to comment.

Mr. DANIELS. Yes. I do not know that I am as bewildered on that point, because I think that insurance companies have historically tried to find those things that were not within our control. Now, admittedly not everything in reproductive health is always in our control—there are certain genetic factors and things like that—but several are, and therefore I think they have fallen outside the purview of the traditional framework in which insurance has developed. So I do not think I find that as surprising.

Senator MIKULSKI. With all due respect, and you understand that we welcome your viewpoint, but I do not understand what you just said.

Mr. DANIELS. OK. I am going to try it again. Traditionally, insurance has assumed that you should be insured for those things that are out of your control. People should be able to control their sexual activity; I mean, they should not be driven by their hormones—and therefore certain services, contraception, etc., in my mind would not be in the insurance plans because they would be the sort of thing that insurance would say the individual can assume responsibility for that activity.

Senator MIKULSKI. Again—and this is not a subject of the hearing—that is my point, that if in fact you want to practice self-help, and you have far greater impulse control than perhaps your partner, the use of an IUD and a diaphragm as techniques that have been around for a substantial number of years is exactly where you are taking control of your life and are looking for the medical tool to be able to do that.

Ms. ROSOFF. Senator Mikulski, I may help in this sense. I keep referring to the historical bias of insurance companies. You may not be aware of this, or you may not remember, but in 1978, Congress actually had to pass legislation called the Pregnancy Discrimination Act of 1978 because insurance companies held that after all, prenatal care and maternity care should not be covered under insurance, because you were in control of the number of children you would have. Most families would decide to have two children, and therefore, you did not need to be insured against that possibility. And from the point of view of the insurance company, it made no difference to them whether you had your two children when you were 16 or 42, or you had them a year apart. For actuarial purposes, it was exactly the same thing. And Congress had to actually pass a law saying to insurance companies that if you provide insurance to your employees, you must treat pregnancy as an insurable condition.

It is the same issue.

Senator MIKULSKI. Betty?

Ms. DOOLEY. Two results of our study from the NMES survey. Expenditures for reproductive services for women of reproductive age totalled in 1993 $40.7 billion, which is one-third of all health expenditures for women in this age group. And I think all of us here would be interested in this, particularly Mr. Daniels and Ms. Rosoff—women of childbearing age in 1993 paid 56 percent of the cost of contraceptives out-of-pocket.

Senator MIKULSKI. Well, that is interesting. Thank you.

Ms. DOOLEY. Thank you.

Senator MIKULSKI. Well, we could talk about what the insurance companies have or have not done. It has been this Senator's experience, going back to her days in the House, when I led the fight to end insurance discrimination against women and then also on women's health, that insurance companies have not always been user-friendly in terms of their policy coverage toward women. But this is not about what the private sector is doing, although we welcome the surveys done.

Before we conclude this panel, I would like to ask Dr. Troyan a question. You heard, and I know you were an avid listener of the questioning of Dr. Lee and the others on the issues related to breast cancer and breast cancer prevention. The subject of mammograms was discussed, I believe, in a very thorough way. But one issue that kept being discussed was something called—and you talk about it, too, Doctor—the "clinical breast exam."

In all of the advice we have gotten as ordinary consumers and so on, we rarely hear that articulated, and I am not sure we even understand what that means. And I would, so that we could have it for the record, appreciate it if, as a clinician, you could describe for us what that is and why that is so important, and do you believe that it is routinely done?

Dr. TROYAN. A clinical breast exam by a health care practitioner is really just a physical exam of the breast. What should be done by the health care practitioner is there should be an inspection phase, where you look to see whether or not there are any skin changes. Then you ask the woman to move her arms around, and you look for dimpling of the skin. As cancers can grab hold of the ligaments that suspend the breast tissue from the muscle out to the skin, any movement of the muscle behind can cause tethering of the skin, and you will see dimpling. So that is another sign we look for.

Then, after we go through the arm movements, then we carefully examine all the lymph node-bearing areas from the breast and make sure we do not feel any increased size of those lymph nodes. And then very carefully, you should examine both breasts and look for any areas that are different, any types of masses.

This is really important because mammography, even in the best of hands, will miss 10 to 15 percent of breast cancers. So it is important to do a breast physical exam. The only part of the breast that gets mammogrammed is the part of the breast they can pull out and press between those two layers. Our breast tissue actually extends far further than the amount of tissue, the comb that they can pull out. We have breast tissue extending up to our collar bones, our lungs, to the middle of our chest, down along our rib cage, and our laterally to our latissimus muscles.

The only way we are going to pick up any cancers in that area is on breast physical exam. So it is important to always couple a breast physical exam with a mammogram.

Even if the cancer is in an area that is covered by mammography, there are some women whose breast tissue is too dense to be able to see it, so it is important to have their breast physical exam in addition to that.

Senator MIKULSKI. Do you think that this is routinely done?

Dr. TROYAN. No, it is not. I think a lot of people depend solely on mammography, and it is important not to do that. Those of us who work within the field are trying to make sure that whenever we talk about mammography, we work very hard to couple it with clinical breast exam because it is very important that both are done.

Senator MIKULSKI. And do you believe that this clinical breast exam should be part of most routine ob-gyn visits?

Dr. TROYAN. Absolutely.

Senator MIKULSKI. And it would not be difficult to do because it is part of what would be considered part of the physical?

Dr. TROYAN. Absolutely.

Senator MIKULSKI. Thank you.

I want to thank the panel, and if you have additional information you wish to submit, that will be most welcome. It has been most informative.

Thank you.

We now turn to our third panel, the providers. This panel consists of a variety of health care providers who will outline the type of services and benefits necessary for women as well as provide the medical and scientific basis for such coverage.

We want to acknowledge that there are a variety of other practitioners who are often involved in the service delivery to women, and this is in no way to minimize the role that they play in the provision of health care. We just wanted to get a core group and be able to have a hearing that was somewhat wieldy, although we knew the questioning would be unwieldy.

So we would like to start off—and we welcome each and every one of you—and we would like to start by turning first to Dr. Luella Klein, who is the past president of the American College of Obstetricians and Gynecologists. Dr. Klein is currently a Charles Howard Candler Professor at Emory University School of Medicine and has most recently served as professor and chair of the department of ob-gyn at Emory School of Medicine.

Dr. Klein, we look forward to your testimony.

STATEMENTS OF DR. LUELLA KLEIN, PAST PRESIDENT, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS; DR. JANET E. FREEDMAN, BOARD OF DIRECTORS, AMERICAN MEDICAL WOMEN'S ASSOCIATION; SUSAN WYSOCKI, AMERICAN NURSES ASSOCIATION; AND JANET KURLAND, NATIONAL ASSOCIATION OF SOCIAL WORKERS

Dr. KLEIN. Madam Chairwoman, I appreciate the opportunity to testify on the importance of a comprehensive benefit package to ensure that the health of our Nation's women is not neglected during the reform of our health system.

I am an ob-gyn who is a primary care provider for women and who trains residents to be primary care providers. I will discuss the President's guaranteed benefits package and the changes that I would recommend to improve it.

The specified benefits are a good first step. Its provisions need to be modified so that all women in this country can receive the care which most women have become accustomed to under the present system.

An annual Pap smear and pelvic examination are recommended by ACOG for all women upon the initiation of sexual activity. After three consecutive annual examinations and negative Pap smears, they could be done less frequently at the discretion of the provider.

However, many women with abnormal Pap smears will require repeat smears at 3 to 6-month intervals.

We also specify annual Pap smears for women who are at risk of sexually transmitted diseases; have or have had multiple sexual partners or, more likely, if their partner has had multiple sexual

partners; or if she smokes cigarettes. These factors all increase the chances that a woman will develop cervical cancer and thus require closer monitoring with annual Pap smears.

All women should have an annual pelvic examination whether or not they have a Pap smear. Pelvic exams are important because they are still the main screening method for ovarian cancer, and they allow the physician to detect cysts, uterine and other tumors, bladder and urinary tract problems, and other abnormalities.

ACOG agrees with the women Senators regarding mammography. We believe that clear, consistent, concise public health messages should be repeated about mammography. Neither the efficacy nor safety of mammograms are in doubt; only their cost.

After careful analysis as detailed in our written statement, the Health Security Act falls short of what I currently recommend for all of my patients—and 90 percent of my patients are in a public inner city hospital—and what I think is best for women. The schedule for Pap smears, pelvic examinations and mammograms is contrary to ACOG's guidelines and contains vague and often confusing legislative language.

Senator MIKULSKI. Yes.

Dr. KLEIN. To clear up the substantial confusion posed by the clinical preventive services chart, ACOG strongly urges that Congress adopt a schedule for Pap smears, pelvic examinations and mammograms that more closely mirrors ACOG's recommendations. Anything less is a disservice to the women of this country. Women's health will not be improved by visiting their doctors every 3 years.

Because of these concerns, ACOG has endorsed Representative Jerrold Nadler's resolution that emphasizes the importance of screening and basic gynecologic care. While there is currently no Senate companion to the resolution, we hope that the subcommittee will consider its goals during debate in the coming months.

We are also disturbed by the use of the term, "fertility-related infectious illnesses." This is not an accepted medical term. We presume the phrase is being used as a euphemism for STDs. Modesty has no place in a bill that will affect everyone's health, especially when STDs such as AIDS, genital warts, herpes, chlamydia, syphilis and gonorrhea are rampant in this country. Like it or not, health care reform is going to have to contain some medical language, however distasteful. Let us not let politically correct or prudish euphemisms stand in the way of public health.

STDs are the most common cause of infertility in the United States and need to be detected and treated.

ACOG is pleased to see that family planning and pregnancy-related services are provided for in the Health Security Act. However, we would urge that a full range of family planning, including reversible contraceptive services, be classified as preventive services and therefore not subject to copayments or deductibles.

More than half of the pregnancies in this country are unplanned,increasing our low birth weight and our infant mortality as well as negatively affecting women's and infants' health. All of these add to our Nation's health care costs and our general assistance programs and could be improved by universal, easily available family planning services.

Without a definition of what is covered under pregnancy-related services, ACOG cannot be specific. We assume that standard prenatal and postnatal services are covered. We also believe that guaranteed private insurance should include abortion care.

In closing, thank you for holding this hearing. The President's guaranteed benefits package will have a major impact on the women of this country. We would like to commend the President and First Lady for taking this major step toward improving women's health. With the changes ACOG has suggested, we believe that women's health and the health of the Nation will be improved.

Financial concerns must not overshadow the lives and health of American women. My guess is that most of the people on the panel get an annual physical examination or visit to their physician, as does the President, and we believe that American women should receive no less.

Thank you very much.

Senator MIKULSKI. Thank you very much, Dr. Klein. That was excellent testimony, and it was quite clear. I am sorry my colleagues could not return—we all have conflicting schedules—but they all have your testimony, as well as that of Dr. Freedman, Ms. Wysocki, and of course, Ms. Kurland.

[The prepared statement of Dr. Klein may be found in the appendix.]

Senator MIKULSKI. I would like now to turn to Dr. Freedman, who serves on the board of directors of the American Medical Women's Association, representing women in medicine since 1915. Dr. Freedman is currently a clinical instructor at the Rusk Institute of Rehabilitation Medicine and is a psychiatrist at St. Claire's Hospital in New York.

Dr. FREEDMAN. Thank you, Senator. Just to correct a common mistake, I am a physiatrist, which is a small, obscure specialty that treats the physically disabled.

Senator MIKULSKI. Say it again, please.

Dr. FREEDMAN. Physiatrist.

Senator MIKULSKI. Physiatry.

Dr. FREEDMAN. The specialty is also called physical medicine and rehabilitation, which is a mouthful.

Senator MIKULSKI. Oh, I am very well familiar with it. My mother would not be at home and as fit for duty as she is after she had her stroke and her diabetic neuropathy situation, had it not been for physiatry.

Dr. FREEDMAN. Thank you, and good morning.

My name is Dr. Janet Freedman, and I am testifying on behalf of the American Medical Women's Association, known as AMWA, the national organization of women physicians and medical students. We are grateful for this opportunity to speak today about women's health needs under health care reform.

As has been repeated many times today, women have a great deal at stake as our Nation prepares to reform the health care system. Under the current system, women are particularly vulnerable to being uninsured and underinsured, and women with access to care often find our health care system ill-equipped to meet our health care needs.

President Clinton's Health Security Act is the only proposal other than the single-payer plan proposal which provides for a full range of services that a woman may require in her life.

Women cannot afford the dangerous leap of faith being asked by the other congressional proposals, which provide absolutely no details as to what benefits are covered.

I would like to discuss today preventive care, reproductive health and abortion, and long-term care and mental health services.

Preventive care is the most valuable tool for ensuring early diagnosis, treatment and disease prevention. Preventive care is provided at a low cost, in outpatient settings, and can be provided by a full range of health care professionals.

We applaud the President's plan for guaranteeing a benefits package with an emphasis on preventive and primary care, but as has already been discussed, we have some concerns about the details of that coverage.

The President's plan does set limits on screening tests such as Pap smears and mammograms. The knowledge of the efficacy of such tests is constantly evolving, and obviously the controversy about mammograms is a classic example. AMWA comes in in favor of keeping mammograms recommended for women beginning at age 40 and annually or every other year until age 50, and then annually after age 50.

We have heard a lot of discussion today about particularly the Canadian study that is the study upon which the changed recommendations are based. There are many flaws in this study. One that has not been mentioned to date is that a number of the participants dropped out of the study because they felt the quality of the mammograms being used was not adequate. To base a change in our recommendations to women under age 50——

Senator MIKULSKI. Excuse me, Dr. Freedman.

Dr. Klein, I saw you nodding your head when Dr. Freedman said that. Do you concur with that?

Dr. KLEIN. Yes.

Senator MIKULSKI. I want the record to show the reservations by both medical societies on why the Canadian study might not be as accurate as has been stated.

Dr. FREEDMAN. The quality of mammograms is based on many things. One is the technique of the technician performing the test; the quality of the machine itself, as well as the reading of the radiologist.

The three American centers that were participating in the study did drop out because of concerns about the quality of the mammogram. To base a public health policy on one possibly faulty test seems rather premature. We generally base our public health policies on a wide body of studies that give us overwhelming or at least a comprehensive picture, and I do not feel that we have that yet for mammography for women under age 50.

AMWA applauds the Health Security Act's inclusion of abortion among covered reproductive health services. The abortion decision is and should remain a private matter between the patient and her physician. Universal coverage of abortion does not sanction abortion nor will it encourage abortion. Rather, universal coverage of abortion assures that our society will accord every woman the same

freedom to determine her health decisions as that enjoyed by men and by women not at risk for pregnancy. And a strong majority of the public supports the coverage of abortion services in the basic benefits package when coupled with thorough contraceptive and family planning coverage. And the charts are gone, but we have seen the variable coverage of contraceptive services, and obviously, AMWA believes that coverage for contraceptive services should be complete both for prescription and nonprescription contraceptives.

Lack of abortion coverage has serious implications for women's health. Restricted access and lack of coverage certainly restricts access, can only lead to diminished quality of care, and particularly place young women, poor women, and rural women at great risk.

We have heard that the majority of women who currently have health insurance coverage also have abortion coverage. If abortion is not included in a new health care plan, there will be an entirely new population of women left out, women who will receive worse care than they currently now receive.

Three other issues must be discussed in relation to abortion. First, it is essential that services be provided to all women confidentially to assure that young women or women in nonsupportive relationships can be free to make personal health decisions without fear.

Second, AMWA is concerned that the Health Security Act's broad "conscience clause" allows health professionals and health facilities to refuse to provide a given service and that this will deny abortion services to higher populations of women, especially those rurally-based.

Third, it is suggested that a compromise can be found by excluding abortion coverage except for those women who purchase an additional rider to the new health plan. Such a proposal asks women to anticipate an unintended pregnancy and to pay more for their health coverage, a requirement not suggested for any other service that is widely covered in the current insurance system. This is medically unsound and economically inequitable.

Briefly, I would like to speak about mental health services. We applaud the recognition that mental health is an essential component of overall health care. Mental health needs to be provided on par with other health care services. Women suffer disproportionately from depression, anxiety disorders and eating disorders and are denied care for most of these conditions. The cost of neglecting this care far outstrips the cost of providing it, and we urge Congress to improve this coverage, not to reduce it.

Finally, long-term care is of particular concern to women. We live longer than men; we are the primary caregivers of our disabled or sick spouses and relatives, but we are often left without care for ourselves.

The Health Security Act addresses long-term care but falls far short of what is needed for comprehensive coverage. Long-term care is limited by a cap, by a fairly restrictive definition of "disability," and by cost-sharing that begins at 150 percent of the poverty level and completely excludes nursing home coverage except for Medicaid participants. Long-term care must also be expanded.

In conclusion, you have an extraordinary opportunity to address the health needs of women comprehensively, sensitively and equi-

tably. Without full access to a range of guaranteed services and full autonomy over personal health care decisions, American women will remain at the bottom tier of a two-tier health care system.

AMWA looks forward to helping the subcommittee and Congress win the quality care that all American women and their families deserve.

Thank you.

[The prepared statement of Dr. Freedman may be found in the appendix.]

Senator MIKULSKI. Thank you very much, and by the way, everyone's entire statements will be in the record, and ACOG's health recommendations will be in the record.

Ms. Wysocki, do you want to proceed now?

Ms. WYSOCKI. Thank you, Madam Chairwoman.

I am Susan Wysocki. I am an ob-gyn nurse practitioner and a member of the American Nurses Association. I am also the executive director of the National Association of Nurse Practitioners in Reproductive Health, and the chair of the National Nurse Practitioner Coalition.

Thank you for inviting us to testify today on the needs of women in a reformed health care system. I am also testifying today on behalf of the American Association of Critical Care Nurses, and it is of note that our original witness is unable to be here today because she is having a breast biopsy for a lesion detected by mammography. She is under 50.

The problems that women uniquely or disproportionately face within our current health care system include lack of comprehensive benefits, limited access to health insurance, barriers to health care services, limitations on choice of health care providers, gaps in knowledge in women's health research, and an overall male bias in the treatment of women in the health care system.

As nurses, we are acutely aware of the problems in the health care system, from the perspective of the provider as well as the health care consumer and the caretaker for our families. Ninety-seven percent of all nurses are women.

We appreciate the opportunity to testify before you today, Madam Chairwoman, and thank you for your continued leadership and support on women's economic and health issues.

For too long, women have been set apart and treated as marginal when it has come to accessing the health care delivery system. Currently, 12 million women have no health insurance of any kind, and millions more have inadequate coverage. In today's society, to be without health insurance is to be without health care. However, even when women gain access to health insurance, barriers continue to limit access to actual health care services.

The American Health Security Act takes a major step in the direction of reorienting and restructuring the health care delivery system to ensure that women have access to health services by maximizing the delivery of primary and preventive care in convenient community-based settings, such as the workplace, schools, day care centers, and at home.

In a restructured health care setting, the hospital would serve as the place where acute health care needs are met, but other health

care sites would be more appropriate, as well as less expensive, for the provision of preventive and primary care.

An example of this type of setting would be a family health center located near a public school and utilized to address the health care needs of American families. These centers would deliver family-focused primary care that is accessible and interlinked with other components of the community's health care delivery system.

The University of Maryland School of Nursing has started a nontraditional storefront site for health care called Open Gate, which has recently opened in Baltimore. The health care facility is staffed by nurses and nurse faculty from the university. Open Gate serves mothers and children who have many unmet health needs. Despite the nearby presence of an excellent traditional health care academic medical center, which we heard much about this morning, the health center draws upon many residents who have psychological barriers or otherwise cannot access the use of traditional, medicine-focused health center.

These types of care arrangements benefit women who, for reasons of family obligation, income limitation, and other reasons, face numerous barriers to accessing actual health care delivery services.

Other health care delivery sites in a restructured health care system must continue to include family planning clinics and birthing centers to meet the reproductive health needs of women. These, I am most familiar with, having been a nurse practitioner for the family planning system in Maine, a consultant to clinics in Pennsylvania, Maryland, New Hampshire, and many, many other States. It is important that family planning clinics be a point of entry to the health care system and that young women do not need a referral to be able to access family planning services and the other preventive services that those clinics offer, including blood pressure screening, Pap smears, breast exams, counseling for preconceptional care, to counseling about diet and exercise that will help minimize the symptoms of menopause.

In a restructured health care system, women should have the option of receiving care from a health care provider of their choice. Providers should not only include physicians, but nurses, including nurse practitioners, certified nurse midwives, clinical nurse specialists, certified registered nurse anesthetists, as well as other nurses and other appropriate providers. By working to balance an individual's health needs with enhanced self-care capabilities and more accessible provider services, health care can be delivered in a more efficient as well as a more coordinated manner that will benefit women's health.

Women must have the option to receive their care from advanced practice nurses—from the ob-gyn nurse practitioner operating a women's wellness center, to the clinical nurse specialist staffing the family planning clinic, to the certified nurse midwife delivering babies at the birthing center, to the gerontological nurse practitioner in the nursing home. These providers play a key role in the delivery of health care to women.

A critical cornerstone of reforming the health care system is ensuring that all individuals have access to and coverage of a comprehensive set of health benefits. ANA believe that a broad standard must be adopted that requires coverage of all services which

are necessary or appropriate for the maintenance and promotion of health. Comprehensive benefits and health services include a full range of preventive services, primary health care services, reproductive health care services, long-term care services, as well as acute and emergency care.

The components of the benefits package should not be left to a national health board or other entity that is not directly responsive to consumer advocacy. In addition, the health services included in the standard benefits package should be provide by a variety of health professionals, licensed or otherwise authorized by the State to deliver those services.

ANA wishes to thank the chairwoman for holding this critical hearing today on the needs and concerns of women's health care in the reformed health care system. We look forward to working with you on these issues as the debate moves forward.

Thank you.

Senator MIKULSKI. Thank you very much for that very comprehensive testimony.

[The prepared statement of Ms. Wysocki may be found in the appendix.]

Senator MIKULSKI. We would now like to turn to Ms. Janet Kurland, who is the assistant director of Older Adult Services at Jewish Family Services in Baltimore. Ms. Kurland is testifying in behalf of the National Association of Social Workers. She is a longtime colleague of this Senator and remembers, I am sure, when we started some programs together many years ago to do outreach, to make sure that senior citizens had access to the medical and social services they needed. She has been a pioneer in her own right in services to the elderly and in terms of the special needs of women and the frail elderly.

Ms. Kurland, we look forward to your testimony.

Ms. KURLAND. Thank you very much, Senator.

I am so pleased to be able to participate today and also to have heard such quality information that this hearing has brought forth today that is essential to all of us.

I represent the National Association of Social Workers today. NASW represents 147,000 professional social workers, two-thirds of whom practice as primary care providers in health and mental health care settings.

Because time is limited, I would like to focus on a few specific areas that have particular relevance to my field of social work practice. They are: comprehensive long-term care services, comprehensive mental health care and substance abuse treatment services, case management as an integral service in health and mental health care delivery, and availability of professional social work services to meet the health and mental health care needs of older women.

In outlining these issues, I will use the President's Health Security Act as my frame of reference. Because of this, I want to be very clear that NASW supports the administration's efforts to boldly move toward health care for all. Additionally, NASW supports the Health Security Act's principles to ensure universal coverage, require all employers to contribute to the cost of health care, establish a comprehensive benefits package, enact systemwide cost con-

trols, and allow State to implement single-payer health care systems. We believe these elements are essential to enactment of meaningful health care reform.

I would also like to point out that with the exception of the single-payer proposals, the President's Health Security Act is the only other health care reform bill that actually addresses the services I will highlight today. Unfortunately, I think that the limitations in the President's proposal have come under such intense scrutiny that the public is unaware that most of the other health care reform proposals do not contain comprehensive benefits at all.

Long-term care services. In brief, overall advantages in the President's proposal for seniors' health care coverage include prescription drug coverage for Medicare beneficiaries; establishment of a new home and community-based long-term care program; prohibition on balance billing in Medicare; significant improvements for seniors in reducing certain cost-sharing requirements, eliminating some gaps in coverage, addressing the insecurity faced by early retirees, and providing additional regulation of the supplemental market.

For older women, the proposal's long-term care benefit is of particular importance, but does contain significant limitations. Nursing home coverage is not included in the benefit and has particular relevance to older women who represent the majority of nursing home patients.

Eligibility for the home and community-based long-term care benefit is based on a beneficiary's need for assistance in performing three activities for daily living, a particularly rigid standard and burdensome for older women living alone who need the service and for older women who serve as caregivers for an elderly parent or spouse. If you cannot feed yourself, how can you stay home alone? That is just one activity of daily living.

Additionally, there is not a defined benefits package for the home and community-based care benefit, so it is uncertain whether older women will actually have access to the kinds of services they need, such as respite care for caregivers.

Although there are long-term care limitations in the Clinton proposal, I want to emphasize again that the President's proposal is one of a few in which these needs are addressed at all. In some of the health care reform bills, not only is long-term care nonexistent, but the proposed dismantling of Medicaid threatens the continued role of Medicaid as the last resort or safety net for nursing home care coverage.

Mental health and substance abuse coverage. NASW believes that equitable coverage for mental health care and substance abuse treatment is critical within a reformed health care system. Given such problems as the high rate of suicide among the elderly, the relationship between emotional stresses and aging, the increase of chronic conditions and their impact upon mental health of the elderly population, and the prevalence of alcohol and other substance abuse problems in our older population, we believe the benefit is particularly important for senior citizens.

Attention to the mental health needs of individuals and their families with chronic and/or life-threatening illnesses is very important. If they are not addressed, the bio-psychosocial needs of indi-

viduals with medical problems may interfere with the medical care treatment plan, may trigger the use of unnecessary medical care, and may result in inappropriate hospitalization or institutionalization.

The President's Health Security Act does not make improvements to the Medicare program's mental health benefit. Consequently, older women, who will continue to utilize Medicare, will also continue to experience the limitations of the Medicare mental health benefit. The primary limitations in this Medicare benefit include the 50 percent consumer coinsurance requirement for outpatient mental health care services and the 190-day lifetime limit for inpatient hospital care.

Limitations in the Health Security Act's mental health and substance abuse benefit that will particularly affect older women who are beneficiaries of the program include financial barriers to access for low-income and middle-income individuals for outpatient psychotherapy services as well as for intensive nonresidential treatment services that extend beyond 60 days. In each of these cases, the beneficiary is expected to contribute a 50 percent coinsurance rate for fee-for-service plans or a high copayment for each managed care visit.

A second limitation is limited inpatient and residential services, compounded by the requirement that consumers "trade off" their inpatient days in order to receive access to intensive nonresidential treatment services; and finally, inappropriate services to people who are dually diagnosed as having a substance abuse disorder and a mental illness. Unfortunately, individuals in this category may quickly exceed the limits in the interim benefits package because the limits on services apply to both benefits.

Case management is of extreme importance to me. Case management, or care coordination, is a service that NASW believes to be essential to delivering quality health, mental health, and long-term care services. For individuals with chronic and/or multiple care needs, we believe case management should be made available at the point of entry.

I think one example will replace many words. Mr. and Mrs. "R" who are 82 and 79 years old live in a small apartment, maybe in Baltimore. A very loving couple, Mr. and Mrs. "R" are devoted to and depend on each other. Because Mr. "R" has crippling arthritis and a debilitating heart condition, he needs assistance with dressing, eating, and getting around. Mrs. "R" is suffering from failing vision. She tries to keep house and cook as best as her limited vision will allow. However, she is not able to drive or shop. She also cannot bathe her husband. Keeping doctors' appointments is sporadic because of their multiple difficulties. There are no children or immediate family in the geographic area to help.

Because of their disabilities, neither can write a check, so money management is a deep concern. The couple's main wish is to continue to live independently in their home without imposing on others. The manager of their apartment building, aware of their many problems, helped them call a local family service agency. A case manager was assigned and is working with them to help fulfill their wish.

After a home visit and assessment with the couple, the case manager was able to locate and place a home health aide in their home. The aide comes to their home for several hours each week to assist Mr. "R" with bathing and grooming. She also does laundry and food shopping for the couple. The case manager also arranges for training for the visually impaired to be brought to their apartment to help Mrs. "R" function more competently and more safely.

Additionally, a bonded fiscal manager was secured to help them with money management. A specialized bubble pack for daily medication allocation was secured to help avoid misuse of medication due to visual impairment. The case manager visits regularly to offer ongoing support and guidance. She also communicates with the "R"'s son, who lives out-of-State, to ease his concern.

Additionally, the case manager has secured a volunteer from a neighborhood group to visit the couple once a week, providing conversation and companionship. When the "R"'s need transportation to a doctor's appointment, a volunteer from another community organization contacted by the case manager drives them there.

This couple, through services secured and coordinated by the case manager, is being helped to stay together in appropriate, familiar surroundings, avoiding or postponing the need for institutionalization.

[The prepared statement of Ms. Kurland may be found in the appendix.]

Senator MIKULSKI. Thank you very much, Ms. Kurland. I know you have other comments related to the need for clinical social work, and we will include your entire statement in the record.

Ms. KURLAND. Thank you. Let me just say one word, Senator Mikulski. Some years ago, I had the opportunity to present testimony before you on the need to enact changes in the Medicaid program to prevent impoverishment of a spouse when the husband or wife was forced to enter a nursing home. I am indeed thankful for your efforts in enacting that change, and we will continue to work with you for enacting these changes.

Senator MIKULSKI. Well, we knew that that was a step, just like many of the benefits in the Clinton plan we know are modest and even skimpy. I think we would be the first to say that the mental health and substance abuse, particularly the mental health benefits, are modest; that it is a first step, but it cannot be the only step. And I think what is the consensus that has come from all of the testimony is that the Clinton health benefit package is the minimum benefit package; it is not the maximum benefit package. And I believe the recommendations are that it should be improved upon as it moves to the floor.

I am not going to go into the mental health benefits because yesterday, former First Ladies Rosalynn Carter and Betty Ford testified on that, and there was additional testimony from others as well.

Later on, in April, I will be holding a hearing on the benefits as they affect senior citizens, particularly the long-term care benefit package and the home-based benefit package. So we will go into that. But I do want to inquire about the issue of case management.

The primary care physician is the medical manager. The family is the care manager. But in between has to be a case manager be-

cause of the social needs of the family, and as you indicated in the case study that you presented, there are other aspects to this. So that the primary responsibility for care is the family. They should be the care manager. But the family should not be the case manager. And I wonder if you would like to comment on the case manager aspect, and do you believe that in the long-term care benefit package, rather than case management being an optional service, that it should be a mandated service?

Ms. KURLAND. First of all, 85 percent of the care today given to seniors is given by families. There is no way we could pick up the total package, and the work is in cooperation with families where they can and how they can.

However, if you know how to access a system—for the best of us, trying to access the system today is hard. To access multiple services means spending hours and hours on the telephone. Families work; they have jobs. You are looking at people in their seventies, eighties, and nineties, and you are looking at a generation of forties, fifties, and sixties, and then you are looking at the twenties, thirties, and forties. We used to be called the "sandwich generation," but I now call it a "double-decker," because there are two generations in between that do care, and they are concerned, and they come to us all the time.

So knowing what services are out there and accessing services, we have to educate families to do what they can, when they can. But if coordinating services puts pressure on that caregiver to the point that he or she can risk losing a job—how many days can you be away from a job? Yes, we are also working on employers. The case management role is to both coordinate and secure the services and to educate the family so that together we can try to put a package together.

Senator MIKULSKI. So you think it should be part of the home-based mandate?

Ms. KURLAND. No question; yes, I do. I think that the Clinton plan at this point includes a case management piece, but it is——

Senator MIKULSKI. But it is optional.

Mr. Kurland. It is not only optional, but I believe it is a very narrowly-defined piece.

Senator MIKULSKI. Well, we would look forward to all of the provider community to give us recommendations particularly for the long-term care. We know that the nurses often also participate in that role.

There are many questions I want to ask, but my own time is such that I will have time for about three more questions, and I would like to have one unique to each panelist. For the nursing community, it seems that the Clinton plan is going to provide new roles for a variety of providers. How do you see health care reform changing the role of nursing?

Ms. WYSOCKI. Actually, I see it more as complementing what nursing is already doing and what nursing has been doing for quite a long time. Nurse practitioners, for example, our reason to be is to provide preventive services, so that this is something that is finally recognizing many of the services that we have already been providing.

In addition, I think that more and more, as services are going out of the hospital and into the community, there will be new roles for nurses in those settings, be it case management type of situations, be it home health nursing, providing care to the elderly at home or to individuals who need health care at home. So there will be a variety of those kinds of roles.

I believe there will be a number of opportunities, judging by the number of people I talk to each week, who are interested—not only nurse practitioners, but all advance practice nurses—in the kinds of care that those individuals can provide.

Senator MIKULSKI. Do you feel that one of the major roles that nursing will now play is in the area of health education and health promotion?

Ms. WYSOCKI. Absolutely.

Senator MIKULSKI. And working with a variety of other providers.

Ms. WYSOCKI. And it should always be emphasized that nurse practitioners and other nurses work in collaboration with other members of the health care system, and that is one of the things that I feel is special about our role, is the emphasis on counseling and teaching and health promotion.

Senator MIKULSKI. Do you feel that the Clinton benefits package is sufficiently clear in essentially bringing in other licensed providers that are complementary to the medical team, to then have that continuum of health care—education, prevention—because not all prevention is technological early detection. Nutrition, the way we eat and the way we live, is a form of prevention. Do you feel the Clinton plan is sufficiently empowering and explicit in that area?

Ms. WYSOCKI. It does save physicians and other health professionals. Where there is some question is whether or not it has the power to actually make sure that panels of providers include nurse practitioners, social workers, and other providers. That, it is not clear about. There is no way to absolutely guarantee that there will not be discrimination against health care providers based on just the fact that they are not physicians.

Also, as you are probably aware, there are also a number of barriers to practice for advanced practice nurses at the State level. And while we would not advocate some type of law that would supersede or preempt all State laws with regard to nursing practice, perhaps there are some other things that could be done short of that to help encourage those States that have fairly arcane nursing practice and medical practice acts to change some of those.

Senator MIKULSKI. Well, I will not use this as a hearing on the manpower needs. When we pass the bill, we are certainly going to go into that. But you see, having spoken at length with both the First Lady and the President, as well as Secretary Shalala, what we hope to achieve in the passage of a bill, which could very likely be a consensus bill, is not just to improve access to health insurance. That is the tool to provide access to health care. Medical treatment will be the core element, but then surrounding the medical treatment, the actual medical treatment, will be others in order to maximize the primary care physician, to ensure proper utilization and follow through on specialists.

I think one of the most important things a physician would say is it is not only what we advise the patient to do, but by gosh, to help them be able to follow through on our advice. Certainly, in physiatry, that is one of the core elements is the sustainability of your plan; am I correct?

Dr. FREEDMAN. Yes.

Senator MIKULSKI. So you see, that is what we hope to achieve, and that is why I was going into those questions. So we will be talking more about that, and as I said to my colleagues, this is not the only hearing we are going to have on women's health.

We would now like to turn to our physicians. I think we have covered very clearly the issues related to recommendations for screening—am I correct—on annual Pap smears and mammograms. There is an identical position between both medical societies; am I correct on that?

Dr. FREEDMAN. Yes.

Dr. KLEIN. Yes.

Senator MIKULSKI. Dr. Klein, this benefit package will be under assault, some on those issues on which good people have differed, like the abortion services. But could you share with us, no matter what we do, what the Congress does, what you think would be the core elements to a benefit package that would meet the needs of women and their families?

Dr. KLEIN. Well, I certainly think that preconception care is very important; that prenatal care is one of our preeminent——

Senator MIKULSKI. That would be the counseling?

Dr. KLEIN. Yes, to evaluate lifestyle, evaluate medical status, evaluate health status, evaluate nutrition, social issues, a variety of things.

Certainly, prenatal care and hospital care, or out-of-hospital care, for labor, delivery, and postpartum care is very important. I do think that family planning has gotten not enough in the Clinton plan, and I have some concern about the screening levels, that once something gets said that this is part of the screening, if you want to do more for an individual for need, that you should not have to waste all of your time justifying that a high-risk person, even if they do not have a lump in their breast, needs to have a diagnostic procedure, because once these things get set, all of us as physicians have had the role in the last few years of all of the paperwork you have to do to justify something that does not exactly fit the screen.

So I think it is important to have some leeway in those issues.

Senator MIKULSKI. And that therefore, when we talk about the additional services that will be defined as medically necessary, you should not have to argue with an 800 number to be able to achieve that; is that right?

Dr. KLEIN. Yes, that is right. And I certainly think that family planning, especially the reversible family planning, should not have copayments. I think the tragedy that more than half of our pregnancies are unintended is partly because of the fact that people have to pay out of pocket all the time for birth control pills, for condoms, and for IUDs. These things are not covered in the same fashion that other things are covered, and they should be our primary preventive kinds of services.

Senator MIKULSKI. Dr. Freedman, how would you comment on that question?

Dr. FREEDMAN. I think I would agree with what Dr. Klein said, and I would like to emphasize that in the Clinton plan, the distinction between preventive services that do not have copays or deductibles and diagnostic services that do is going to be very confusing to the patient. Why, for this Pap smear, do I not pay a deductible, but the 6-month follow-up one, I do, because I had a diagnosis from the first one.

Senator MIKULSKI. And it adds the hassle in the provider's office.

Dr. FREEDMAN. It certainly is a hassle to the provider to keep track of that, collect that, as the plan is currently structured, cycle money around to the plan or to the health alliance. And to try to be clear with your patient as to what recommendations are when there is a second confusing listing, one from column A, two from column B, is not going to encourage utilization of these services.

People in general avoid health care. Small numbers of people seek more than they should have. I think that most women do not get the mammograms they should have, not only because they do not have coverage, but they avoid them. And reducing the screening schedules to a minimum of what might be acceptable for very healthy women will drop most women under that level, and then to divide up similar types of treatment from the patient standpoint into preventive, diagnostic, etc., I think is just another hurdle and another barrier.

Senator MIKULSKI. And also for the physician, isn't it?

Dr. FREEDMAN. It certainly is for the physician. In addition to the precertification type of requirements that Dr. Klein referred to, just the actual doing requirements are another hurdle to jump through. And that is something that I think the Clinton plan strives to reduce, and this is an area where the reduction is not where it should be.

Senator MIKULSKI. I would like you to add one other part to your testimony. Both Dr. Klein and you have spoken about the needs of women, particularly during their reproductive years. Because of your expertise in physiatry, would you also comment on what you think would be the effect of the proposed Clinton benefits package and the long-term care and home and community-based benefits package, because that has a tremendous impact on women, both because we live longer, we are the ones who are the caregivers, as Ms. Kurland articulated.

Dr. FREEDMAN. I think most

people right now are quite shocked when they learn how little their insurance covers. They are astounded. They do not understand that physical therapy may not be covered, that a wheelchair may not be covered, let alone the significant expense of a nursing home.

The plan does have some coverage for acute rehabilitation. I have some concerns about a managed care setting for rehabilitation because we do not have good definitions of what is necessary or not necessary. I think the Clinton plan is an improvement for some people who right now have zero coverage for any type of long-term care, chronic care, or acute rehabilitation care. And those people do

not even know they do not have coverage, and they would benefit. But for a significant number of people, there is a reduction.

In a number of States, the Medicaid population currently has better coverage than the Clinton plan; a number of States have less. This might average it out, but it will result in a reduction for a number of disabled people who currently are covered under Medicaid because that is the only coverage they can receive.

So I think that it also is a small first step in long-term care, but we cannot think that it is really going to answer our needs.

Senator MIKULSKI. Dr. Freedman, as I said, in April, we will be holding a hearing—since this is the Subcommittee on Aging and Life Cycle Issues—pretty good, don't you think—on the benefits as they affect senior citizens, and we would welcome any views that you and others in the field of rehabilitation would like to share with us.

Dr. FREEDMAN. Thank you.

Senator MIKULSKI. Dr. Klein, did you want to comment?

Dr. KLEIN. I think it is very important to say that in preventive services, as time passes, it will be significantly important that hormone replacement therapy, properly managed, may contribute remarkably to women's long-term health and prevent hip fractures and the kinds of disabilities that may be prevented by appropriate kinds of new medical care that are not enjoyed by a very large group of women in this country.

Ms. WYSOCKI. If I could just say one other thing, this morning, Senator Murray asked if there was anything that women could do about preventing ovarian cancer, and there was a long answer about screening and new technology. But there actually is something that women can do to prevent ovarian cancer, or reduce the incidence, and that is the use of oral contraceptives, which also reduce the incidence of endometrial cancer. So many American women do not know that and should know that, so I did want to bring that up at this time.

Senator MIKULSKI. We who are concerned and who have devoted our lives to being interested in issues related to health care and who have taken particular interest in women's health have felt that the lack of research, both some of the original attitudinal and even prejudicial attitudes to not including us in clinical trials, and then also philosophical and ideological reasons that prevent research not only in fetal tissue but also in terms of fertility—there is such skimpy research on fertility, not only research that would help people to deal with unwanted pregnancies, but also for those families that want to have children. So we would hope that we can break through this, for even a greater array for family planning, to really look at the full consequences of oral contraceptives. It gets mixed reviews, as you know, Ms. Wysocki; you articulated one. So we really do need research in that area.

So what I hope you saw as this went forth—I have gotten several notes, and Senator Kassebaum has been unable to come back—but we the women in the Senate intend to work on a bipartisan basis on these issues.

Second, we do have the support of many of the men within the U.S. Senate, so it is not a "guy/gal" thing. And we so thank you for your very complete, comprehensive and clear testimony. I must

say that just as there was this "new world order" up here for the United States, certainly as we look at the provider team here, it really shows the new face, if you will, or not so new—the newly recognized—no, no, I am not talking about our age—serving women since 1915, the nurses and the social workers.

So know that although you were the last panel to testify, you were certainly among the most valued participants in our hearing today. And as we move ahead, even after we pass a health insurance bill—and I believe we will—there will be the issues of implementation, of making sure that the manpower needs are articulated, of making sure that the implementation is done and the need for oversight, the fact of how it gets put into practice, to make sure that there are not, then, new kinds of barriers that are administrative and bureaucratic.

So we will have many conversations. I know that the women want to deal with research, access, accuracy, and also the attitudinal approaches.

So we thank you for all of your comments and look forward to working with you.

This hearing is adjourned, and the record will remain open for 10 days for additional comments.

[The appendix follows.]

APPENDIX

Prepared Statement of Senator Boxer

Madam Chair and Mr. Chairman, thank you very much for giving me the opportunity to join you at this hearing which is on an issue of critical importance to all of us: Women's health care.

When we talk about health care reform, we need to make one point very clear: it will be impossible for us to enact meaningful reform without addressing the health care needs of women.

12.7 million women in the United States between the ages of 18 and 64 are uninsured. The President's Health Security Act goes a long way toward offering comprehensive care to the women of this Nation. Under this legislation, every woman, no matter where she lives or how she lives, will have coverage for a comprehensive set of benefits that can never be taken away. The guaranteed benefits package ensures coverage for the full range of reproductive health services, including family planning and abortion. It requires no copayments or deductibles for a core set of preventive services—from pap smears to prenatal care to mammograms. And the bill improves access to all of these services by designating obstetrician-gynecologists as primary care providers.

There are those who will try to play politics with these issues and argue that abortion should not be included in the benefits package. I strongly disagree. I believe that we need to be clear about what this issue is and what it is not. We are not talking about providing women with a "new benefit." We are not talking about providing them with additional coverage. We are talking about offering women the same coverage and benefits that they already receive from most private health insurers.

In fact, today we will hear the preliminary results of the largest survey of private health insurance plans. This survey shows that 66% of large group fee-for-service policies and 70% of HMOs routinely cover abortion services.

These insurance corporations share a belief held by the President, by this Senator and by the women of this Nation: our private health care decisions should be made in the doctor's office, not in the Halls of Congress.

Finally, I have some concerns about the limitations for coverage of pelvic examinations, pap smears and mammograms in the President's bill. These decisions must be based on the highest medical standards and I am therefore very pleased that we have medical experts here today to testify about the appropriate guidelines for these procedures.

I would also encourage the administration and this subcommittee to consider changes to ensure that primary care providers are properly trained to recognize domestic violence, a grave public health threat for women.

Thank you once again for giving me this opportunity to be here today. I look forward to working with you to ensure that health care reform protects this Nation's women and doesn't leave any of them out in the world.

Prepared Statement of Senator Feinstein

I want to first thank Senators Mikulski and Kennedy for calling this hearing.

While women make up at least half of the population of the United States, there is still not equity in health care coverage.

And as this Nation considers various health care reform packages, I believe it is critical to take a careful look at health care coverage for women, focusing especially on the issues of access, benefits, and cost.

At present, women's health care is clearly inequitable. Since so many women work in low-wage jobs, change jobs, and take care of children, women are more likely to live in poverty and have limited access to regular health care services—including prenatal care, mammograms, and other preventative services.

According to the Congressional Caucus for Women's Issues: Two-thirds of all part-time workers are women; nationwide, only 37 percent of all women get their health insurance through an employer; AIDS has become a critical issue for women, who are becoming infected at increasing rates; and the cost of health insurance is higher than it is for men.

In addition, because women live longer than men, they often face additional barriers to receiving health care coverage—such as the expense of long-term and home health services—and Congress must understand these issues.

In the last year, many of us have worked to:

Remove restrictions on access to abortions for Federal employees (Treasury-Postal appropriations bill), poor women (Labor-HHS appropriations bill), and all women who wish to use family planning clinics (Freedom of Access to Clinic Entrances Act).

Increase funding for breast cancer research by 40 percent from the previous year—to a record $296 million.

Increase funding for Women, Infants and Children program by 11 percent from 1993 to a high of $3.21 billion.

Add to the National Institutes of Health a new program to include women in clinical trials. No longer will key research be conducted without the participation of women.

Yet, clearly, more needs to be done.

In the coming year, we are working to pass the Women's Health Equity Act, sponsored by our dean—Senator Barbara Mikulski:

32 separate bills that cover a spectrum of women's health issues, including breast and ovarian cancer, osteoporosis, AIDS, clinical trials, Lupus, and training for women in health professions.

For my part, I will introduce the Ovarian Cancer Research and Information Act that will increase research funding and creates a national database for ovarian cancer research.

Looking ahead, our focus must now turn to the issue of women's health equity—and, specifically, how the health care plan now under discussion must address the need for all women to have basic health care.

While the President's Health Security Act contains many necessary women's health services, its benefits package is currently under intense scrutiny by those who would limit women's access to adequate health care.

In addition, questions remain about the affordability, accessibility, and frequency of clinical and preventative health care services (e.g., mammographies and abortion services) provided in the Clinton or any other plan.

However, the President's bill is precise in describing what will and will not be included, and this stands in stark contrast to other health care bills that do not detail what benefits will be included. Instead—as has been noted by female Members of the House in a recently published letter—other bills create a national commission to determine basic benefits, with relatively limited Congressional involvement.

With my colleagues, I will be watching these issues carefully during the upcoming weeks and months, and working hard to make sure that women have the best health care—affordable, equitable, and complete—as possible.

Prepared Statement of Senator Moseley-Braun

Good morning. I applaud my colleagues, Senators Kennedy and Mikulski, for convening this hearing and inviting me to participate. For far too long the health needs of women have been overlooked, and treatment and prevention efforts underfunded. Health care reform offers an opportunity to improve access to quality health care for all Americans—especially women and children.

This Congress and this administration are committed to giving more than lip service to the needs of women. No longer will women and minorities be shut out of clinical trials, no longer will breast cancer, a cancer that kills one in nine women, be denied the research dollars that are so greatly needed, and no longer will the health needs of the Nation's children be neglected. Your leadership, Senator Kennedy and Senator Mikulski, and that of this administration, clearly signals a shift of attention in favor of improving the health status of all of our people.

Last year, this Congress passed and the President signed the Family and Medical Leave Act. Legislative action is also proceeding in areas like child care, violence against women, and biomedical research initiatives, among others. And no legislative initiative will help women more than comprehensive health care reform.

For women and their families, words like security, accessibility, and portability are much more than cleverly worded sound bites; they can be the difference between employment and empowerment, or remaining on assistance.

As the witnesses here today will attest, women's health needs are very different from the health needs of men—for example, areas like prenatal care, geriatric services, and even mental illnesses such as depression are of special importance to women. We can only enact real, meaningful reform if there is adequate recognition of the special needs of women.

Reform will really benefit women and families. We know that our current system is often unfair and inequitable. Over 12 million women have no health insurance and millions more have inadequate coverage. Women also incur higher out-of-pocket costs for themselves and their offspring than men and poor women often have great-

er out-of-pocket costs, as a percent of income, than middle class women. We also know that poor women, particularly minority women, receive less preventive care.

Comprehensive health care reform will improve the health status of women and their families. The legislation proposed by President Clinton addresses all of the priority issues that must be addressed for reform to successful, including: Universal access to affordable care; cost savings; quality; and choice.

Coverage must be affordable or the universal access goal can not be reached. Choice of provider and availability of a wide range of preventive and clinical services is also important for every American and especially for women in their reproductive years. Women also comprise a large portion of the part time and low wage workers and are thus more likely to be uninsured. For those in these categories who seek insurance, coverage is often too expensive and therefore out of reach.

The Clinton bill takes care of a big part of this problem by pulling in part-time workers who often do not receive health insurance through their employer. Now part-time workers will finally have access to coverage. The Clinton plan also includes a much needed emphasis on primary and preventive care. This focus is really key for women and children. What this means is that there will be increased access to mammographies and prenatal and well baby care. It also means a greater number of our children will be immunized against devastating illnesses.

In this,—the richest country in the world, 20 percent of our children did not visit a doctor in 1992, 50 percent of inner city children have not been immunized against preventable diseases, and 9 million children are uninsured. Those figures, and many, many others I could cite, are a clear illustration that more preventive and primary care is essential.

Reform means the availability of comprehensive affordable services for all Americans. It means a healthy society for all of us. Health care reform is good for the country, good for families, and good for women. I look forward to working with my colleagues to pass comprehensive health care reform this year.

Prepared Statement of Dr. Philip Lee

Madame Chairman and Members of the Committee: I am pleased to come before you today to talk about women's health under the Health Security Act. The Act represents the President's commitment to all Americans, but particularly to American women. The Act guarantees the kinds of care and research that are needed to protect women's health and to guarantee access to comprehensive care for all women.

THE NEW HEALTH-ORIENTED FRAMEWORK OF REFORM

The President's plan has a new health-oriented approach that emphasizes personal accountability, disease prevention, and a close working relationship between the personal care and public health systems.

Central to this approach is a restructuring of the personal health care system, enabling it—for the first time—to focus on keeping women healthy.

The President's Health Security Act is committed to guaranteeing that all women have access to preventive and diagnostic services that are so critical to their physical and emotional well being.

The Act is designed to address many of the barriers women face today:

Women, because on average they earn less than men, are disproportionately affected by soaring health care costs. Health care reform will make insurance affordable and keep down out-of-pocket expenditures. Women of reproductive age pay 68% more out of pocket health care costs than men.

Women make up a larger portion of the population holding part-time jobs and clerical or sales jobs—jobs which usually do not offer health insurance to employees.

Many women must rely on their spouses for health insurance, and risk being dropped if they are divorced or widowed.

Women are especially likely to change their work status during their child bearing and child raising years, causing them to risk loosing their health insurance benefits.

In 1992 there were over 2 million uninsured children under 18 living in families that are headed by single women. Women bear a major responsibility for the health needs of uninsured children.

Women make up nearly four-fifths of the informal caregivers who assist the more disabled elderly—that is, those who need help with one or more basic daily living tasks, including bathing, dressing, transferring, toileting or eating.

Women tend to live longer and require more long-term care and home health services that are often not affordable or available.

Madame Chairman, the Health Security Act addresses many of these barriers by guaranteeing every woman health insurance protection regardless of employment status, health, income or age. The Act allows every woman to maintain health care coverage even if she switches jobs or loses her job—with no interruption in health care delivery or change in choice of physicians. The Act eliminates pre-existing condition clauses which are often used to exclude women from receiving prenatal care coverage and other important benefits. The Act provides a benefit package which includes a broad range of health services and which focuses on prevention and primary care, services particularly important to women. All Americans will have comprehensive benefits including clinical preventive services without deductibles or copayments.

Regional alliances and health plans will be responsible for making sure that their populations have access to these covered services. Report cards on each health plan will focus plan's attention on achieving healthy outcomes for their members and will allow their members to monitor how well they will accomplish their goals. To the extent health plans' enrollees are kept healthy, plan health care costs will be lower and premiums paid by individuals and employers will be lower.

GUARANTEED BENEFITS

One of the most significant parts of the Health Security Act for women is the guarantee of comprehensive benefits for all and with no lifetime limit on those benefits. This is particularly important because of the serious health problems women face today. For example:

One in eight women in the U.S. will develop breast cancer in her lifetime. In the United States 1.6 million women have breast cancer today, and this year approximately 182,000 American women will be diagnosed with the disease, approximately one woman every three minutes.

In 1990 only 49 percent of women age 50 and above had a mammogram in the previous two years. And in 1992, women earning under $10,000 a year were 30 percent less likely to have had a mammogram in the last year than women earning more than $20,000.

In 1991 early prenatal care was received by less than two-thirds of Black, Mexican American, Puerto Rican, Central and South American, or American Indian mothers. Pregnant women who receive no prenatal care or care only in the final trimester are more likely to have a low birth weight baby, to have their baby die, or to die themselves of pregnancy-related complications.

The Health Security plan also includes coverage for the full range of pregnancy-related services. To encourage their use, the plan covers prenatal care and one postpartum visit with no cost-sharing. Delivery-care is covered, and may have cost sharing depending on the woman's plan. Voluntary family planning services, including all contraceptives that are approved by the FDA and are dispensed by prescription, will be covered. As with other services, the choice of necessary and appropriate reproductive health care services will be left to a woman and her health care provider. Women at risk for sexually transmitted diseases can be screened with no cost-sharing. When additional testing is medically necessary or appropriate, such as when a woman presents symptoms, it will be provided with cost-sharing.

INVESTMENT IN PUBLIC HEALTH AND PREVENTION

Madame Chairman, these changes in the personal health care system mean that health plans will focus on keeping women healthy. In doing so, health plans and alliances will work closely with public health agencies. These changes in the personal health care system also make it possible to refocus the public health system on protecting and promoting the health of women in our communities.

When public health fails, people and communities suffer and personal health care costs increase. For instance, substance abuse is not only an epidemic in and of itself; it is also at the root of other public health problems. Substance abusers are the fastest growing segment of the HIV/AIDS population, and substance abusers with AIDS are a major factor in the spread of multi-drug resistant tuberculosis. Fifteen percent of women delivering babies in Harlem Hospital use cocaine. According to the Center on Addiction and Substance Abuse at Columbia University, substance abuse is currently estimated to add $140 billion to our country's direct and indirect health care costs every year, including $500 million to treat cocaine-affected infants during their first month of life.

Reforming the public health system is not supplemental to health care reform. It is an integral part of achieving the goals of reform. The programs outlined in Title III—the Public Health Initiatives—of the Health Security Act are the means by which the President proposes to strengthen and refocus the public health system.

The success of these programs will improve health security for all Americans and reduce health disparities among Americans and particularly women. They will help contain accelerating health care costs.

The Health Security Act will address many of these problems because health plans will focus on primary and preventive care. This will enhance women's ability to obtain services such as prenatal care, mammography, pap smears, contraceptive drugs and devices, family planning counseling and services, and mental health services.

It is particularly important that reform will provide greater access to screening for breast and cervical cancers. Without action to increase high quality screening and follow-up services, breast and cervical cancer will take the lives of more than one half million women during the 1990s. Poor, elderly and minority women are least likely to be screened for breast and cervical cancer. Women with low incomes, particularly those who are uninsured, often have difficulty obtaining these services. Under the Health Security Act, women will be guaranteed a comprehensive package of benefits that will include unprecedented coverage of a and Pap smears with no cost-sharing.

The clinical preventive services included in the President's plan are based on our best scientific information, including the recommendations of the U.S. Preventive Services Task Force. In addition, our mammography benefits are consistent with those recently recommended by the National Cancer Institute (NCI) which found that routine screening mammography in women over the age of 50 will reduce the risk that a woman will die of breast cancer by approximately one-third. In a dramatic step forward, clinical preventive services are provided at no charge to detect disease early and to encourage healthy behaviors.

Covered services include the following:

Women age 20-39 will be covered for physical examinations every 3 years with no cost-sharing, including pap smears and clinical breast exams.

Women age 40-49 will be covered for physical exams every 2 years with no cost-sharing, including pap smears and clinical breast exams.

Women age 50-64 will be covered for physical exams every 2 years with no cost-sharing, including pap smears and clinical breast exams. In addition, these women can receive mammograms every 2 years with no cost-sharing.

Women who are defined as high risk for certain medical conditions will also be eligible to receive additional services, or more frequent tests, including mammograms or pap smears, with no cost-sharing.

Independent of these clinical preventive services women of any age can receive health care services, including clinical breast exams and mammograms, at any time when it is medically necessary or appropriate, with cost-sharing, depending on their plan.

MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES

Some of the most common mental disorders, including depression and some anxiety disorders, strike approximately twice as many women as men. The substance abuse and mental illness benefits will provide important services for Americans with these disorders and eliminate preexisting condition exclusions and lifetime limits. In addition, there will be activities authorized in Title III to ensure access to the new mental illness and substance abuse benefits.

WOMEN AS MOTHERS

The Health Security Act also gives women the security that their children will have access to health insurance and to guaranteed benefits. The comprehensive benefit package will include childhood immunizations, regular check-ups, and preventive services for children, including vision and dental care.

WOMEN AS CAREGIVERS

We know that women are particularly concerned about the later years of life for themselves and for their loved ones. Women provide much of the long-term care for their families. However, because women generally out-live men, they find themselves without caregivers in their time of need for such services.

Comprehensive coverage of preventive care and medical treatment goes a long way toward easing the threat of disease that faces all women and their families in America. But women who need long term care or who have relatives with chronic health problems or severe disabilities face special challenges.

The new long-term care program will provide a range of community supports to people with severe disabilities, regardless of their age or income. A principal goal

of this new program is to increase the independence of people with disabilities, support them to remain in their own homes or in other community settings, and reduce the burdens on family members and other informal caregivers, most of whom are women.

TITLE III: THE PUBLIC HEALTH INITIATIVES

The Health Security Act includes a Public Health Initiative which will enhance efforts at health promotion and disease prevention, health services research and prevention research, and will ensure that women will have access to the services covered in the comprehensive benefits, including an adequate number of providers to deliver health care services to women in medically underserved areas.

IMPROVING ACCESS OF HEALTH CARE SERVICES TO WOMEN

The President recognizes that insurance coverage alone cannot meet the needs of all Americans. To help improve access to appropriate care and to help prevent disease and promote health, the Health Security Act includes several new investment proposals that are particularly important to adolescents and young women.

To ensure access to health services for urban and rural medically underserved populations, the Act calls for expanding the Community and Migrant Health Center programs. An additional annual appropriation of $100 million for the years 1995 through 2000 would be authorized by this bill. The Health Security Act also proposes to establish a program of grants, loans and loan guarantees for consortia of public and private health care providers to develop community practice networks or establish their own community-based health plans.

In addition, there will be funds authorized to provide enabling services such as transportation, translation and child care services to ensure that women have access to the new benefits provided in the Comprehensive Benefit package.

WORKFORCE DEVELOPMENT

Essential to improving the health of women is investing in primary care and in the training of primary care doctors (which includes pediatricians, obstetricians and family physicians) and other health professionals (including nurse clinicians. The Health Security Act provides increased funds for training in primary care. In addition, the Act expands the National Health Service Corps five-fold, increasing the number of primary care providers serving in underserved areas. Investment in our health care work force will ensure that vulnerable populations, including children and expectant mothers, will have access to adequate numbers of providers who will deliver appropriate medical care.

SCHOOL BASED HEALTH SERVICES AND HEALTH EDUCATION

The Act includes two new grant programs to support school health education programs and to fund school health services. Under the Act, $50 million in FY 1995 will be authorized to support the planning and implementation of comprehensive school health education programs for children in kindergarten through grade 12.

In addition, the Act authorizes $100 million in FY 1996 rising to $400 million per year by 1999, to help fund school health services including preventive health services, mental health and social service counseling, substance abuse counseling, care coordination and outreach, management of simple illness and injuries, and referral and follow-up for more serious conditions. These funds will be targeted to adolescents and communities most in need of support.

WOMEN'S HEALTH RESEARCH

Women are more likely to have greater disability and poorer health outcomes than men and the incidence of certain life threatening illness is increasing among women, yet they have been at the bottom of the medical research agenda. The Act calls for an expanded program of prevention research at the National Institutes of Health. Among the research priorities outlined in the bill are birth defects, prenatal care, adolescent health, mental health and substance abuse, reproductive health, breast cancer and Alzheimer's disease. The bill would authorize $400 million for fiscal year 1995, and $500 million for each of the fiscal years 1996 through 2000.

The Public Health Initiative expands health services research in the Agency for Health Care Policy and Research. Health services research will provide the information we need to improve the quality and outcomes of medical care, improve appropriateness and cost effectiveness of health care delivery systems, and help consumers make wise choices about their providers and health plans.

CORE PUBLIC HEALTH FUNCTIONS

Finally, new funding will also be authorized to improve the core public health functions of health promotion and disease prevention. In addition, new funds will help support and prevention initiatives to address health issues that affect local communities or specific populations within communities. Many of these problems do not affect the country uniformly and call for tailored interventions. This initiative will be of special importance to the health of children, including immunizations,lead poisoning screenings, health education and violence prevention.

CONCLUSION

Madame Chairman, the Health Security Act was designed to guarantee all women access to comprehensive health care. The President has taken a bold step in spelling out that guarantee. Every woman can be assured that she will have the benefits that she needs. All women would now have access to a revitalized health care system that not only prevents disease and promotes health, but is also there when they or a loved one becomes ill. Madame Chairman, I'd be happy to respond to questions.

PREPARED STATEMENT OF DR. SAMUEL BRODER

Good morning, Madame Chair, and Members of the subcommittee. I am Dr. Samuel Broder, Director of the National Cancer Institute (NCI). Thank you for the opportunity to appear before you today to discuss NCI's research on breast cancer, the NCI position on screening for breast and cervical cancers, and the scientific basis for that position. Breast cancer and cervical cancer are two areas critical to women's health.

Cancer is the second leading cause of death among women in the United States. In 1994, about 250,000 women will die of all cancers combined, about 46,000 dying of breast cancer. It is the most common cause of death from any cause in women aged 40-44. Since 1987, breast cancer incidence, fortunately, has reached a plateau and has actually decreased slightly. However, from 1973 until 1987 the incidence of breast cancer showed a steady increase. Although there are now slight decreases, the situation is dire. Some of the past increase in incidence over the 1980s is attributed to increased detection due to mammography; the longer term increase is less well understood. We do not believe that the increase can be fully understood without more basic research.

Turning to cervical cancer, in 1994, 15,000 American women will be diagnosed with this disease and 4,600 will die. Fortunately, the incidence of invasive cervical cancer and the death rate have decreased in the United States over the past several years, because the Pap screening test can detect the pre-malignant or in situ stage. The Pap test, developed by George Papanicolaou, has been used since the 1940's. This test, like others, has limitations. The early stage can be effectively treated, and yet, even here, there are problems as sometimes the cells captured during the procedure are not the atypical ones. Beyond that, some women are not being screened at all and even among those who are screened, some are not being treated. Even when the cells are accurately gathered, not all tests are read and interpreted accurately. NCI has worked to improve the reading of the Pap test and has introduced the "Bethesda system" which has clarified and standardized reporting. Despite these problems, the Pap test is an excellent tool, even when its limitations are taken into account. As a result of our investment in basic research, we are making good progress on a possible vaccine against cervical cancer. The ability to create such a vaccine grew out of years of research on viral carcinogenesis.

The issue of mammography is an area of intense polarization between various groups at this time. The polarization has occurred not because of fundamental differences—we all share the concern that women are dying of breast cancer—but because we have different perspectives on this problem. The key question before us all is how to go about reducing the devastating toll of breast cancer and other cancers.

The NCI is a scientific institution, a biomedical research institution committed to generating the knowledge needed to reduce the suffering and death from cancer. While at times there have been bursts of enthusiasm for research advances that promised to cure cancer, we all recognize that cancer has not been cured. Today, there are exciting developments on many fronts, particularly in basic research, but as we discuss these achievements, we must acknowledge that cancer poses an awesome research and therapeutic challenge. We must have no illusions on this point.

As a scientific organization, we know that individual opinions and practices may require adjustments or fundamental changes as we learn more facts about normal biology, more about the cancer cell and have more opportunity to assess diagnostic

tools and treatments. At the same time, we have seen that yesterday's "incurable and fatal" disease can be tomorrow's medical triumph, and that a disease that terrorizes one generation may be only dimly remembered by the next generation. Two principles need to guide us wherever possible: the consensus of scientific peer groups and clinical trials as the instrument for consensus wherever possible.

Each of us has a role to play in this enormously important effort to save the lives of American women. I believe that NCI's role is the generation of knowledge, the sharing of that knowledge and translation of scientific knowledge into clinical reality at the community level. We could not advocate a treatment being continued if followup clinical trials showed that its benefits were initially overstated, that in truth, it brought no reduction in deaths in the real world. By the same rules, we must adhere to what we have learned about the value of mammography for women in various age groups. After a process of scientific evaluation, after extensive review of data from a number of clinical trials, after internal and external debate, and most important of all, after seeking the input and advice of our most respected non-governmental experts, we have an obligation to share the results of this process with the women of America. We owe it to them to provide the most accurate information available about screening and treatment of breast and cervical cancer at a point in time. In the case of mammography, a routine program of screening will definitely save lives. This technology has been proven in randomized clinical trials for women over age 50, and moreover there is a clear and unmistakable consensus on this point. For women under 50, neither condition applies at this time.

One point must be emphasized: this discussion does not address diagnostic mammography, where a doctor and woman are joined in following symptoms or other indications, such as a lump, pain, or swelling, of a possible malignancy. That is a different situation entirely. Here, in this discussion, we are focusing on the concept of screening in women who are free from known signs or symptoms.

It is important to note that mammography is only one of several screening technologies being examined by NCI. For example, a large clinical trial, the Prostate, Lung, Colorectal, and Ovarian (PLCO) trial, has begun to evaluate screening tests in these cancers. This study will assess the predictive value of the widely used test for prostate specific antigen (PSA) and less used technology such as ultrasound, CA 125 or flexible sigmoidoscopy. In women, for instance, the study is designed to determine if screening with pelvic examination plus serum CA 125 and transvaginal ultrasound can reduce deaths from ovarian cancer. Thus, for tests such as PSA, we are not recommending its adoption as a routine screening tool until clinical trials and/or a scientific consensus permit us to do so.

The rank-and-file scientists who work in the National Cancer Program, both intramural and extramural, are superb and they are a dedicated group of men and women. They are working to find new ways to prevent, detect and treat breast and cervical cancer. NCI supports research aimed at locating important genes and genetic processes in breast cancer. Research is being carried out on specific inherited gene abnormalities and certain familial predispositions to breast cancer including benign proliferative breast disease; the Li-Fraumeni syndrome, in which family members inherit a mutation in the p53 tumor suppressor gene, located on the short arm of chromosome 17; and early-onset familial breast cancer, linked to abnormalities also on chromosome 17 referred to as Breast Cancer-1 or BRCA-1.

Collaborations with the National Center for Human Genome Research are designed to elucidate genetic information about breast cancer. On December 2, 1993, we were pleased to announce the finding of a gene for colon cancer that also appears to play a role in ovarian, uterine and several other cancers. When genes are found, tests can be developed to show which women are at risk. Sometimes the genetic discovery will aid in developing vaccines or new prevention strategies.

At times, conditions not typically thought to fall within a definition of women's health are of surpassing importance. Thus, the gene for Ataxia-Telangiectasia when carried by an otherwise normal woman can predispose her to radiation damage and breast cancer. As carcinogenesis studies progress, this information could be used to counsel women at high risk to avoid certain environmental exposures and to undertake individualized programs of screening and prevention. We are looking specifically at breast cancer and the interaction of various occupational and environmental hazards in the NCI Long Island Breast Cancer Study Project. This will provide information not only for New Yorkers, but for women everywhere.

Genetic discoveries will yield new molecular tests that might have high specificity. We are not waiting for these events to occur. We are working to refine our knowledge of the tools we have, including mammography and Pap tests. We are encouraging the development of new digital mammography techniques, which would also allow transmittal of images for consultation or diagnosis by specialists. New imaging techniques are being used to more accurately guide biopsies and surgery. Other

methods are borrowing from space or defense department technology. We have high hopes for new technologies such as digital mammography and magnetic resonance imaging and other methods which enhance imaging. This is a very unusual time of flux in the science of breast imaging. We are continuing to stimulate the development of innovative methods of imaging the radiographically denser breast tissue of younger women—tissue that can be exceedingly difficult to image with conventional mammography. We continue to work toward simple screening tests, possibly blood tests, that would pick up molecular evidence of breast cancer or breast cancer susceptibility, and at the same time, might be the basis for new and effective therapies. Next month, NCI will co-sponsor with the American Cancer Society a workshop on research issues in breast cancer screening. Through the workshop, we will identify areas for further research and establish priorities for tackling these research questions.

NCI research has shown that the impact of cancer in general on minority and underserved populations is disproportionately great. This impact is certainly felt in breast and cervical cancer incidence and mortality rates. Even where incidence rates are lower for African-American women than for white women, as is the case with breast cancer in women ages 40 and over, the mortality rates of African-American women are higher. Cervical cancer incidence rates for African-American women are about twice the rates for white women, and mortality rates are about three times the rates for white women.

Screening and access to screening are only one aspect of this very complex situation, one that tangles economic issues, educational issues, access to screening and diagnosis and access to treatment with many other variables including genetic and environmental ones. Mammography has seemed to be a successful way to introduce some underserved women into the medical system. In some ways, it has become a metaphor for concern about breast cancer, even a way a woman could express her determination to protect her health. But mammography was never designed to do all that—it is a medical tool. Mammography was designed to screen for breast cancer and where it is efficient and there are other benefits, that is all to the good. Thus, for women over 50, mammography is an established screening tool.But there is extreme disagreement concerning women under age 50. Therefore, in this setting, we must state what we know and what we do not know.

A word about the history of NCI recommendations is in order. In 1987 the NCI developed Working Guidelines for the early detection of cervical and breast cancers. These guidelines provided the American public with a summary of the state of knowledge at the time.[1] The guidelines regarding screening mammography for breast cancer detection (which can be defined as a regularly performed mammogram for a woman with no presumptive evidence or symptoms of breast cancer) were as follows:

> The screening process should begin by age forty and consist of annual clinical examination with screening mammography performed at one to two year intervals.
>
> Beginning at age fifty both clinical examination and mammography should be performed on an annual basis.
>
> Physicians should encourage women to perform monthly breast self-examinations.

At the time these guidelines were developed, evidence for screening was strongest in women ages 50-69, although the Health Insurance Plan (HIP) of Greater New York clinical trial had shown a reduction in cancer deaths due to screening in a group of young and older women all mixed together. The above guidelines were considered working guidelines with the intent to revisit them should any new information become available.

Similarly, the working guidelines for cervical cancer screening developed in 1988 are as follows:

> All women who are or who have been sexually active or who have reached the age of 18 years should have an annual Pap test and pelvic examination.
>
> After a woman has had three or more consecutive, satisfactory, normal annual examinations, the Pap test may be performed less frequently at the discretion of her physician.

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[1] It is important to stress that none of these guidelines pertain to diagnostic mammography, which is performed as a result of a clinical suspicion (such as a lump or nipple discharge). In the setting of a clinical suspicion, whether because of symptoms or physical findings, mammography is generally a necessary medical tool.

Over the ensuing six years there has been no new information to contradict the basic message of the original guidelines on cervical cancer and the consensus among scientists has held firm. Over the last two to three years, however, several events have led to an ongoing re-evaluation of the breast cancer screening guidelines:

First, an NCI-supported meeting entitled "Forum on Breast Cancer Screening in Older Women" was convened in April 1992. Among the recommendations was the following: "There was enough direct evidence to support a recommendation for universal screening in women sixty-five to seventy-four years of age. Because of the lack of direct evidence regarding screening efficacy and because of increasing occurrence of multiple chronic diseases in women seventy-five years of age and older, the Forum concluded that clinical judgment was necessary to weigh the relative benefits of co-morbidity and screening effectiveness for the individual patient in this age group Regarding the interval for mammography and clinical breast examination, the Forum concluded that there was no evidence to choose one interval over another, since apparently equally effective intervals have ranged from twelve to thirty-three months."

Second, the Canadian National Breast Screening Study of screening women in their forties, published in November 1992, did not show a mortality benefit ascribed to mammography after seven years of follow-up. Dr. Anthony Miller presented a preliminary analysis of this study in closed session to the Board of Scientific Counselors of the NCI's Division of Cancer Prevention and Control (DCPC) as far back as October 1991.

Third, an overview analysis of five randomized screening trials conducted in Sweden in the 1970's was reported early in 1993. The study found that the largest reduction of breast cancer mortality, roughly one-third, was observed among women aged 50-69 at randomization. Among women aged 40-49 at randomization, no statistically significant difference was observed.

I would like now to briefly discuss the process by which NCI came to the specific change under discussion today, but before doing so, I want to put to rest the concern that the NCI's position is influenced by political considerations or expediency.

This process was, in one way, initiated in 1991. It was obvious that there was a need to evaluate the new information in the context of the large body of evidence which had evolved since the landmark Health Insurance Plan (HIP) study of thirty years ago. Following a prepublication, closed briefing in the Fall of 1991 on the Canadian mammography study, NCI began planning a major international workshop of breast cancer screening that was held in February 1993. Many of the scientists who performed the studies, as well as researchers in breast cancer screening fields, participated in this workshop. Results from all eight published randomized clinical trials of screening mammography were reviewed. At that workshop an overview analysis, a meta-analysis, was presented by New Zealand investigators of all the randomized screening trials in the world. This analysis raised questions regarding the benefit of screening women between the ages of 40-49. This workshop was open to both the press and the public. At that time, NCI provided information and resources to the media, interested voluntary, advocacy and health professional organizations, and the public, on the mammography screening studies that were being reviewed.

The final report of the workshop concluded:

First, "The randomized trials of women ages 40-49 are consistent in showing no statistically significant benefit in mortality after 10-12 years of follow-up . . . . For this age group, it is clear that in the first 5-7 years there is no reduction in mortality from breast cancer that can be attributed to screening. There is an uncertain and, if present, marginal reduction in mortality at about 10-12 years. Only one study provides information on long-term effects beyond 12 years, and more information is needed."

Second, "For women ages 50-69, the evidence presented at the Workshop strengthens the scientific observation that screening leads to reduced breast cancer mortality. Every study presented found a protective effect for women in this age group. The Swedish studies suggest that a screening mammogram as infrequent as every 33 months reduces breast cancer mortality, at least in a population with a high compliance rate and in a setting with high-quality mammography. These data raise the possibility that a screening interval of every 12 months may not be necessary in this population."

Third, "Women in their 70's are a high risk group for breast cancer. The currently available clinical trial data for these women are inadequate to judge the effectiveness of screening because the numbers of women were small, the compliance was poor, and the screening episodes were too few."

The Workshop charge was to critically review and summarize the scientific evidence, not to develop guidelines per se. In response to this analysis, NCI staff began the process of reviewing our Working Guidelines in the context of the new information. NCI has a responsibility to provide accurate, clear information to the public-based on scientific evidence. This information clearly held an important public health message for all women and health care professionals.

Subsequently the following process has taken place:

During the period from May through August 1993, the NCI PDQ Editorial Board, consisting of both NIH and non-NIH researchers, reviewed and endorsed Workshop results; the NCI staff developed draft guidelines/recommendations which were reviewed by the NCI Executive Committee; NCI staff also met with the American Cancer Society (ACS) to discuss principles underlying the NCI draft guidelines.

In September 1993 the draft guidelines were reviewed and discussed by PHS agencies and selected participants from the February 1993 International Workshop on Breast Cancer Screening; NCI staff met with the ACS Breast Cancer Subcommittee, the National Cancer Advisory Board, and with individual members of the DCPC Board of Scientific Counselors to discuss proposed guidelines.

During October 1993, NCI disseminated draft guidelines and other materials to agencies involved in earlier guidelines and voluntary advocacy groups, with a request for written comments and attendance at the then upcoming October 21 meeting of the NCI DCPC Board of Scientific Counselors.

On October 21, 1993, the guidelines were reviewed by the DCPC Board of Scientific Counselors, who passed a motion recommending that the existing recommendations for women 50 years and over be maintained, and that for women under age 50 NCI provide a summary of existing evidence and data and suggest that these be discussed with each woman's physician or health care provider. In effect, the Board wanted to present the facts, without the pronouncement of a guideline.

On November 22-23, 1993 the National Cancer Advisory Board passed the following motion: "Recognizing that there is controversy on the effectiveness of mammography for women under the age of 50 that calls for more research, the members of the National Cancer Advisory Board recommend that the National Cancer Institute defer action on recommending any changes in breast cancer screening guidelines at this time."

On December 3, after careful consideration of the conflicting advice of scientific experts, NCI released the following statement summarizing our position on breast cancer screening:

> "There is a general consensus among experts that routine screening every 1 to 2 years with mammography and clinical breast examination can reduce breast cancer mortality by about one-third for women ages 50 and over.
>
> Experts do not agree on the role of routine screening mammography for women ages 40 to 49. To date, randomized clinical trials have not shown a statistically significant reduction in mortality for women under the age of 50."

On February 23, 1994, the National Cancer Advisory Board passed the following motion:

> "Inasmuch as cancer research is the primary mission of the National Cancer Institute, the NCAB recommends that the NCI not involve itself independently in the setting of health care policy."

Several points are worth stressing. The current NCI position is in close alignment with the positions of several public and private organizations—e.g., the National Women's Health Network, the U.S Preventive Services Task Force, the American College of Physicians, and the American Association of Family Practitioners. Moreover, there is a growing feeling among our advisory groups that NCI must stick to science and the generation of knowledge and allow other appropriate government agencies to take the lead in the formulation of guidelines that speak to reimbursement and related issues.

The change has been controversial, but the process has been open and candid. We have extended our outreach to many diverse groups, both scientists and consumer advocates. We have heard from women's advocacy groups who strongly oppose the use of routine mammography in women under 50 and those who with equal force hold the opposite view. NCI has been intensively reviewing the state of the science regarding mammography screening efficacy for at least two years. After the Workshop conclusions were clear, NCI conducted surveys and focus groups with women

and health care professionals to anticipate issues which might help to prepare health professionals and the public for such changes.

Results from the surveys and focus groups indicated that women clearly understand that scientific debate on health issues is sometimes unavoidable.

The NCI maintains communication with many voluntary, advocacy and health professional organizations in the areas of cancer prevention, early detection, and treatment. NCI has redoubled its efforts to stay in close communication with these organizations and to assist where possible in minimizing the confusion that often occurs when recommendations change. And yet, we sometimes must differ even while we may at the same time respect and admire those who disagree with us.

On December 3, 1993, NCI released the new mammography statement and simultaneously communicated with all its own units including the Cancer Information Service—which answers inquiries via the toll-free 1-800-4-Cancer telephone number, the National Black Leadership Initiative on Cancer, the National Hispanic Leadership Initiative on Cancer, the Appalachian Leadership Initiative on Cancer; the Cancer Centers Public Affairs Network; and the Centers for Disease Control and Prevention to determine the strategies and tools needed to convey NCI's breast cancer screening messages in light of the latest scientific review. NCI immediately began updating its own publications and developing a consumer brochure that explains the new position on breast cancer screening for women 40 and over.

The NCI Division of Cancer Prevention and Control is planning a meeting of organizations within the Public Health Service to determine how best to work together on this issue and to organize an ad hoc committee of NCI staff as a first step to develop effective strategies to educate physicians and other health care providers on the new NCI mammography statement.

Perhaps most importantly, NCI staff will continue to meet with breast cancer advocacy groups and voluntary organizations, such as the American Cancer Society (ACS), to clarify issues, identify common ground—and there is common ground—foster cooperation, and explore joint communication efforts, where this is possible.

Madame Chair, I welcome your interest and the interest of this Committee and the Congress in this issue. Please allow me to repeat myself: Each of us has a role to play in this enormously important effort to save the lives of American women. This dialogue on mammography is part of the effort. NCI must generate and assess knowledge and then assist in translation of scientific knowledge into the care given at the community level. Science is not separate from life, it is our effort to understand life. NCI's recommendations must be based on scientific evidence to the greatest extent possible, and they must change as new information becomes available. Thank you, Madame Chair, for this opportunity to testify. I would be pleased to answer any questions you or other members of the committee may have.

Prepared Statement of Scott Daniels

Thank you, Senator Mikulski. I recognize your leadership on the women's health issues. You don't know this, but you gained my respect a few years ago when you participated in a discussion on women's health at the National Institutes- for Health. At that time, I was serving as Executive Assistant to the Assistant Secretary of Health for the U.S. Public Health Service—Dr. James O. Mason. Those discussions that day were robust, as have been your subsequent hearings on the topic. I don't expect this morning will be any different.

I know firsthand the importance of your hearings on women's health this morning. My wife Connie—a mother of two children (Andrew Scott, age 4, and Melissa Christine, age 7),—is a breast cancer survivor. Although we live with a great deal of uncertainty about the future, because of early diagnosis, we have been given much hope. I genuinely wish the same for other women.

I am here this morning representing The Family Research Council, a Washington-based research organization that analyzes the impact of national policy on America's families. We have several concerns about the role of the family in health care reform, especially the President's plan. But this morning I am here only to address the question of whether or not every American be forced by federal law to pay for abortion on demand through government-mandated "premiums" and other taxes.

With respect to his plan for national health care reform, President Clinton is being pressured to fulfill his commitment to the pro-abortion special interest groups and to push for the inclusion of elective abortion coverage in the standard health benefits package. If the abortion advocates prevail, this means not only that every American woman will be able to receive an abortion on demand, but also that every American citizen will be required to pay for abortion insurance, thus helping to finance the "choices" of others.

In advocating abortion coverage in the standard health benefits package, pro-abortion activists have recently rallied behind the rhetoric of "preserving the status quo." Ironically,however, their argument for the status quo has been undermined by one of abortion's strongest proponents. In a speech given on July 12, 1993, Pamela Maraldo, president of the Planned Parenthood Federation of America, said that "the inclusion of reproductive health services [including all abortion services] in a basic benefits package will truly constitute the 'defining moment' for reproductive rights in America." She said that the inclusion of abortion is equivalent in importance to Roe vs. Wade. Ms. Maraldo has helped to set the record straight.

The Clinton plan in actuality is an extreme position. It would mandate that all Americans and institutions pay for abortion irrespective of their deeply held and conscientious beliefs on elective abortion. By contrast, the true status quo is that coverage of elective abortion in private health insurance is voluntary not mandatory.

At this point, I would briefly like to examine abortion coverage in private insurance in terms of its prescriptive and descriptive elements. We have arrived at these conclusions as the basis of conducting our own informal survey last summer. (With your permission I would like to submit the longer paper for the record.)

A fairminded assessment of this complicated question must recognize two dimensions to addressing this issue. Part of this issue is descriptive, that is, what is/are the current practice(s) among insurance companies. The other is a prescriptive, or an ethical issue.

First, the descriptive analysis is extremely subjective when establishing methodological controls that are unbiased. There are hundreds of insurance companies, comprised of different types of plans, subject to employer desires, and the like. This means, for instance, that a large insurance company may offer abortion coverage in certain policies, but exclude it from others that they offer. Furthermore, the question is complicated by the definition of abortion itself: does the term "abortion" in survey questions refer to cases where the life of the mother is threatened or to elective services? This methodological subjectivity results in a false perception that providing "abortion services" necessarily means covering "elective abortion." This is a misperception. Coverage of "abortion services" does not necessarily mean that elective abortion is covered.

Second, and more fundamentally, is the prescriptive element in this issue. Even if a reasonable description can be determined, does this mean that the present voluntary system should be overthrown for a mandatory system? Health care reform really turns on this question alone.

Rather than ask the question, "What is done?", we should instead ask, "What ought to be done?" Many Americans, myself included, think there are good reasons not to mandate abortion coverage in private insurance. The issue is whether or not to make abortion on demand a mandatory service which Americans must pay for. Here are the consequence of such a policy. First, institutions which have a religious and moral aversion to elective abortion, but which also have a compassionate desire to cover the general public and the uninsured, would be forced to include abortion on demand in their health plans. (For this reason the existing conscience clause for providers is inadequate.) Second, forced payment of abortion is highly controversial as evidenced by all of the recent public opinion polls. Third, abortion will sabotage needed reforms in the current health care delivery system that benefit America's families. Congress has consistently recognized the divisive nature of abortion coverage in private insurance in passing federal laws. Over the last decade, the Hyde Amendment, the 1978 Pregnancy Discrimination Act, Title XIII HMO Amendments to the Omnibus Act of 1988, and the Education Amendments to the 1988 Civil Rights Restoration Act have all ensured that employers and insurers have the option whether or not to cover abortion. Clearly in its oversight of the private insurance market, Congress has obviously been able to discern that abortion on demand is not a medical procedure for which Americans should be forced to pay.

To make abortion part of his common comprehensive benefit package as the President intends to do, and so require the policyholders to finance abortions, regardless of their moral sensitivities, is not merely unprecedented, but goes beyond any semblance of tolerance.

Prepared Statement of Susan L. Troyan

This year in the United States more than 180,000 women will be diagnosed with breast cancer and more than 46,000 women will die of the disease. It is estimated that one in eight women in the United States will develop breast cancer in her lifetime. Breast cancer is the most common cancer among women and the second leading cause of cancer death in women.

We know how to prevent nearly 90% of lung cancers which are the leading cause of cancer death. There is no known method to prevent breast cancer. The best way to prevent a disease is to understand what causes it. We do not understand what causes breast cancer. If the cause is unknown then we look at the risk factors associated with the disease to see if we can avoid them. The three major risk factors for breast cancer are age, a family history of breast cancer in a first degree family member, and a prior history of breast cancer. We can change none of these major risk factors. Just as important is the realization that 80% of women who develop breast cancer do not have any of these major risk factors . It is important to educate women that the risk factor for breast cancer is having breasts; all women are at risk.

Until research reveals the cause(s) of breast cancer and we learn methods of prevention, it is important to be able to detect this disease in its earliest stages when treatment is more likely to be effective. There are three methods of screening for breast cancer: breast self exam (BSE), clinical breast exam by a health care practitioner (CBE), and mammography. Although BSE is widely promoted, studies evaluating this method do not show a decrease in mortality between women who perform it and women who do not. CBE has been shown to be useful in conjunction with mammography. Screening mammography is currently our best method of detecting breast cancer. Studies have shown that regular screening mammograms can decrease the mortality form breast cancer by 30%. This reduction in deaths is greater than with any of our treatment methods including chemotherapy and hormone therapy.

Mammography is a specialized x-ray of the breast. It works by showing a difference in density of tissues. Fat has a low density on mammography while glandular tissue has a higher density. Both benign lumps and cancers also have a higher density. When women are younger they have more glandular tissue creating a dense white background on mammogram which may obscure vision of a small cancer developing. As women age the glandular tissue decreases and their breast are mostly fatty tissue allowing better vision of the higher density of a small breast cancer against the low density background of fat. Therefore mammography becomes more sensitive as women age. This is not an abrupt change, it is gradual. The ages over which this occurs and the extent with which it occurs is different for every women.

Consensus guidelines for screening were agreed upon in the 1980's so that consistent recommendations could be made by different practitioners decreasing confusion and allowing greater education. These were agreed upon recognizing that we did not have all the scientific data necessary to make definitive statements. These guidelines for mammography are: First screening mammogram by age 40; mammograms every one to two years between ages 40 and 50; and yearly mammograms over the age of 50.

The results of screening studies are now coming in. There is clearly a decrease in mortality from breast cancer in women screened over the age of 50. Studies have not yet shown a decrease in mortality for women under the age of 50. Experts are divided as to whether mammographic screening is not effective in this age group or whether these results merely reflect the fact that most of these studies were not designed to look at this age group separately. The Canadian study which was designed to do so has been criticized as being too short in follow up and having flaws in the design.

There is clearly as yet no definitive scientific evidence which can tell us that mammography is or is not effective in reducing the death rate from breast cancer in women under the age of 50. With such controversy I would caution against changing guidelines for screening at this time. At present screening mammography coupled with clinical breast exam are our only tools for the earlier detection of breast cancer. Women must have access to quality screening mammograms. If health care reform does not cover the current screening guidelines, women in many states may have a decrease in coverage. These are women who have up to now managed to continue insurance coverage or health plans which cover mammography (often mandated by state law) in spite of the seemingly endless preexisting conditions used to exclude them from coverage. Health care reform should assure universal coverage as well as outreach to underserved women.

Clearly we need to realize mammography is far from optimal. As we attempt to solve these screening issues we must look for better detection methods. Even in women over the age of 50 regular screening mammograms will only reduce the risk of death, not eliminate it. This is because invasive breast cancers are felt to be growing for 6-8 years before they are large enough to be seen on mammogram. During this period of time cancer cells can be leaving the breast through lymph vessels and blood vessels. In some women the body's immune system is unable to kill all of the cells and spread to other organs will have occurred before we are able to de-

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tect a cancer. We need more basic science research which can tell us what is occurring as a cell changes into a cancer. We need to develop a biochemical test where blood or urine samples can be screened and detect these early changes. We need treatments that can intervene and reverse the process as well as improved breast imaging to locate the cancers in those who screen positive.

PREPARED STATEMENT OF DR. JANET FREEDMAN

Good morning Madame Chairwoman and Members of the subcommittee. Thank you for the opportunity to appear before you today. I am Dr. Janet Freedman, and I am testifying on behalf of the American Medical Women's Association (AMWA), a national organization of women physicians and medical students. I currently serve as Co-Chair of AMWA's Committee on Health Care Reform. I am also Assistant Professor of Rehabilitation Medicine at Bellevue Hospital in New York. AMWA is grateful for the opportunity to speak today about women's health needs under health care reform, and to voice its strong support for the Health Security Act's inclusion of a guaranteed, comprehensive benefits package.

AMWA was founded in 1915 to support women in medicine and to promote women's health. Our 13,000 members practice in virtually every medical specialty and practice setting. Above all, AMWA is committed to ensuring that the interests of women patients are served under health care reform. And indeed, we believe that we are uniquely positioned to comment on the need for reform of women's health care. As women seeking care for ourselves and our families, we consume the majority of our nation's health care services, yet are consistently faced with the shortcomings oil today's system in dealing with our own diverse needs. As women physicians, our numbers are concentrated in the primary care specialties which deliver the bulk of the medical services to women and their families,specifically obstetrics/gynecology, internal medicine, family medicine, and pediatrics.

Women have a great deal at stake as our nation prepares to overhaul its health care system. As our scientific research community, our Congress, and our medical schools are launching new initiatives to better address women's health needs, we must assure that our health care delivery system similarly opens its doors and equips itself to treat women as whole patients—not second-class patients, not isolated organ systems. Under the current system, women are particularly vulnerable to being uninsured or underinsured because we earn less than men, make up the majority of the part-time work force, and are more likely than men to be insured through our spouses. Nearly twelve million women have no health insurance of any kind. Furthermore, women are the primary caregivers to our nation's children, often fulfilling this role alone; therefore a lack of coverage for women often translates into a lack of coverage for entire families.

In addition to these barriers to care, women also face a health delivery and insurance system ill equipped to respond to our health needs. Medically essential and potentially cost saving services, such as mammograms, Pap smears, family planning services, and contraceptive drugs, are not covered by many private insurance companies. Women patients present myriad health concerns which are unique to women (such as pregnancy), predominate in women (such as osteoporosis or depression), or manifest themselves differently in women (such as heart disease). Women's health care delivery must reflect this, and be as comprehensive and complete as that of the rest of the population. Women's time-consuming roles, both at home and at work, must also be recognized as potential barriers to our receiving care. Care must be provided in a variety of accessible settings, with an emphasis upon community-based care, and appropriate enabling services—such as child care and transportation—should be available.

Finally, AMWA feels that it is crucial that under health care reform we reverse, not perpetuate, the charged political climate which has historically driven public policy relating to women's reproductive needs—specifically, our need for abortion services. Women's well-being, autonomy, and capacity to participate fully in society depends upon our ability to make informed decisions, in conjunction with our physicians, about every aspect of our personal health.

President Clinton's Health Security Act is the only proposal, other than the McDermott/Wellstone single payer plan, which provides for the continuum of preventive primary, acute, and long-term services which a woman may require in the course of her life, no matter where she lives, whether she is married, or how much she earns. AMWA is firm that without this specificity of services, American women—and all patients—cannot hope for real reform. AMWA heartily concurs with the 29 women Members of Congress who recently wrote a letter to their colleague, Congressman Jim Cooper: We cannot afford the dangerous leap of faith being asked by his and other congressional proposals which provide no details for covered serv-

ices. Nor can we accurately determine the cost of a new health care system if the covered benefits are not first defined.

PREVENTIVE AND PRIMARY CARE

Comprehensive preventive and primary care are among the most valuable tools available to us for fostering early diagnosis and treatment, as well as serious disease prevention, thereby improving overall health and decreasing the need for expensive acute care. Most of these services can be provided at low cost, in out-patient settings, and by a range of health care professionals. In our "Model Benefits Package for Women," AMWA recommends preventive care such as patient education about behaviors related to smoking, nutrition, exercise, chemical dependency, and sexuality, and preventive procedures including cholesterol checks and immunizations. Comprehensive primary care for women must include the age-appropriate screenings and examinations, such as screening and treatment for sexually transmitted diseases (STDs), family planning services, contraception (drugs and devices), infertility treatment, abortion, pre-natal and post-partum care, Pap smears and mammograms, mental health and substance abuse services, and osteoporosis detection and treatment.

The Clinton plan, by specifically outlining a broad range of preventive and primary services, takes important steps toward curtailing the major killers and disablers of American women, such as heart disease; lung cancer; breast cancer; osteoporosis; domestic abuse; and HIV/AIDS. The proposal also assures access to care in a variety of settings, such as community-based and home-based care, and with a variety of providers, which both improve access for women and lower costs. AMWA strongly supports the appropriate utilization of the skills of all members of the health care team, under the supervision of physicians. Finally, the Clinton plan will not exclude patients due to their pre-existing conditions, which is vital to including all women in the new health care system.

Again, AMWA applauds President Clinton's commitment to guaranteeing a specific, comprehensive benefits package, and finds the plan generally complete in this area. AMWA believes, however, that the age and frequency limits placed upon coverage of mammography and Pap smear services should be broadened in order to assure optimal care for women patients. Furthermore, we are concerned that the plan's covered reproductive health services are not outlined fully enough, and are subject to numerous cost-sharing requirements which could severely hamper access for low-income populations. And finally, AMWA believes that access to abortion must be assured in more explicit language than is currently written in the Health Security Act.

MAMMOGRAPHY COVERAGE

AMWA is firm that legislation must not dictate the intervals at which any medical procedure is covered. The body of knowledge about the efficacy of such techniques is constantly evolving, particularly in the area of women's health. The current intense debate over mammography's efficacy, for example, reflects the substantial gaps in our knowledge created by years of neglect. Health care reform must reflect this environment, and enable physicians and their women patients to make independent decisions according to their best judgment, based on available scientific evidence.

Until a well-designed, randomized, controlled clinical trial is conducted in the U.S., AMWA maintains that mammography services should be available to all women aged 40 to 49 at one to two year intervals, and annually after age 50. The Health Security Act, however, only reimburses for screening mammograms every two years after age 50. Although exceptions are made for women under 50 with family risk factors for breast cancer, those women account for only a small percentage (17 percent) of the women diagnosed with breast cancer in this country. Greater latitude must be afforded all physicians and their women patients.

Breast cancer remains the second leading cause of cancer deaths in women in the United States. Almost two million women will be diagnosed with the disease in the next decade, and approximately 450,000 will lose their lives to the disease within the same time frame. Perhaps even more important, given the current debate surrounding the efficacy of mammography for women under age 50, there are an estimated 33,000 American women between the ages of 40 and 49 who are living with breast cancer during any given year.

Typically, breast cancer is a relatively slow-growing tumor. By the time the tumor can be first found on a mammogram, it has been present in the breast for an average of eight years. When the tumor is palpable, it has been present for about ten years. Given this perspective, we can hardly consider our current detection methods

to be "early." For the moment, however, mammography and physical breast examination are our only detection techniques. The sooner that breast cancer is diagnosed, the better the chances for survival.

There are no valid current clinical studies of the efficacy of screening mammography in the United States at this time. The last randomized controlled U.S. clinical trial was conducted in the 1960's, and the last worldwide screening study began in 1980. Our nation's scientists are working to correct this situation, most notably through the NIH's Women's Health Initiative study, but it will be years before the results of these studies will be available to us as practitioners, and to you, as policymakers.

Some argue that there has not been a clear connection established between early detection by mammography and a reduction in mortality among women aged 40 to 49. A Canadian study released last year is the example most often cited to support this assertion. AMWA believes that the significant debate within the medical community about the accuracy of the Canadian research must be taken extremely seriously. Major policy decisions here in the U.S. must not be based upon this lone, highly controversial study. The Canadian study was widely criticized for the poor quality of mammography it offered, for subjecting many women in the control group to mammography, and for including many women with advanced tumors in the test group. In fact, the three American physicians participating in the study resigned, citing poor quality mammography as the reason for their resignations.

Furthermore, even if it is ultimately established that mortality is indeed not reduced among women aged 40 to 49, there is substantial evidence that morbidity (degree of suffering and seriousness of treatment) is substantially reduced' if breast cancer is diagnosed through mammography at this early stage.

In addition, AMWA is confident that the recently adopted National Mammography Quality Standards Act will have a significant impact upon the efficacy of mammography for all women who receive screening. Mammography's ability to save lives has yet to be studied in the U.S. under these new guidelines for uniform, high quality mammography in all centers around the nation.

PAP SMEARS AND PELVIC EXAMINATIONS

Again, AMWA opposes legislation which mandates schedules for screening procedures. Physicians and their women patients must maintain discretion over the intervals at which such tests are performed, in accordance with established medical guidelines. Those guidelines currently recommend annual Pap smears and pelvic exams for all sexually active women and all women over age 18. After three normal smears have been obtained, and it has been determined by the health care provider that the woman has no other risk factors, the Pap smear may be performed every three years, but the pelvic exam should still be performed annually.

The Health Security Act falls short in this area by only covering Pap smears and pelvic exams every three years after three normal smears have been obtained. After age 40, the tests may be performed every two years. Exceptions are made only for women "at risk for fertility-related illnesses." These exceptions do not account, however, for women presenting risk factors such as HIV, tobacco use, or multiple sex partners, all of which warrant annual Pap smears, according to the American College of Obstetricians and Gynecologists (ACOG). ACOG also recommends annual pelvic exams for all women.

REPRODUCTIVE HEALTH AND FAMILY PLANNING

The Health Security Act's laudable commitment to preventive care falls somewhat short in its treatment of women's reproductive health and family planning needs, particularly for low-income populations. Under the proposal, all of these services—except for prenatal and postpartum care—are subject to deductibles and cost-sharing requirements, unless a woman is eligible for Aid to Families with Dependent Children (AFDC) or her family's income is below 150 percent of poverty. Furthermore, without explicit coverage of contraceptive drugs—whether under the family planning portion of the bill or the outpatient prescription drug provision—low-income women may be at risk for having to pay twice; that is, a woman may have to first meet deductible requirements for both the family planning medical visit and for the drugs prescribed, while also having to pay co-payments for those services.

In addition, screening and treatment for only some of the debilitating sexually transmitted diseases which threaten women's health are covered under the Health Security Act. Because the plan indicates coverage for "fertility-related infections"—such as gonorrhea and chlamydia—other dangerous diseases, including syphilis, which are only sexually-transmitted, are excluded.

Finally, in the area of maternity care, many low-income women will take a step backward in terms of their completeness of coverage under the Health Security Act. Although for the poorest women such services themselves are exempt from cost-sharing under the plan, low-income women will nonetheless be forced to pay a portion of their insurance premiums in order to be covered by the Health Security Act itself. And for women who currently receive free pre- and post-partum care under Medicaid—with incomes which place them below 185 percent of the poverty level—will under the Health Security Act be subject to co-payments, a new financial burden which will possibly deny them care altogether.

ABORTION COVERAGE

AMWA particularly applauds the Health Security Act's inclusion of the full range of reproductive health services for women, including abortion. As women physicians from a broad range of religious and philosophical backgrounds, AMWA members are committed to their belief that the abortion decision is a private medical matter between a patient and her physician. Although AMWA is firm that health care reform must also include full access to family planning and contraceptives, the unfortunate medical reality for the foreseeable future is that more than a million American women each year will need abortion services.

Indeed, over half of all pregnancies are unplanned, and half of those are terminated—resulting in 1.6 million abortions annually. There are now approximately 20 million women living in the United States who have had an abortion. These numbers are high for a variety of educational, sociocultural, economic, and public health policy reasons which are beyond the scope of today's discussion. But it is crucial to note that no current method of contraception—even oral contraceptives, Norplant, and Depo-Provera—is one hundred percent effective; almost half of the women who unintentionally become pregnant each year are using contraceptives. In addition, our research community has not aggressively pursued improved contraceptive options for women and men. Because women are fertile for over thirty years—and are sexually active for most of that period—and because they are so often inadequately equipped to protect against unintended pregnancy, abortion's place on the list of women's fundamental health care needs must be recognized.

AMWA strongly rejects any suggestion that universal coverage of abortion sanctions abortion, or will in any way encourage abortion. Rather, universal coverage of abortion services assures that our society will implement health policy which accords every woman the same freedom to determine her own health decisions as that enjoyed by men, and by women not at risk for pregnancy. And indeed, recent polling indicates that a strong majority (70%) of the public support the coverage of abortion services in a basic benefits package. The American people know that guaranteed access to abortion care will leave health decisionmaking in the hands of women patients, not the government.

Lack of coverage for abortion services has serious implications for the health of American women. Studies available to us on this subject tell us that restricted access, and lack of affordability most certainly restricts access, can only lead to diminished quality of medical care. I would like to quote from one of the most important of these studies, a report issued two years ago by the American Medical Association, Induced Termination of Pregnancy Before and After Roe v. Wade: Trends in Mortality and Morbidity of Women. The report details in full the dangers of withholding coverage of abortion services: "If national or state funding regulations . . . deter or delay women from seeking an early termination of pregnancy . . . then more women are likely to bear unwanted children, continue a potentially health-threatening pregnancy to term, or undergo abortion procedures that would endanger their health."

If this debate is to be distilled to its essence, however, the most salient point of all is the fact that we can no longer afford to deliver one standard of care to people with ample financial resources, and another, lesser one, to those without. This is the situation which currently exists for millions in America, and which the Clinton plan's massive health care reform effort is intended to remedy. The denial of abortion services in the nation's health care plan will effectively sanction gender, race, and class discrimination, and is inexcusable,both medically and ethically.

Furthermore, denial of abortion services ensures that the two-tiered health care system now in place will not only persist, but actually worsen. We know that a majority of women who currently have health insurance coverage also have abortion coverage. Unless abortion is included in the White House health care proposal, there will be an entirely new population of women left out in the cold—not poor, not rich, just getting by. If abortion coverage is excluded for these women, the health care

plan would deliver worse health care than they now receive. Health care reform will not be a success if women—or any patient—receives substandard, incomplete care.

There are three other issues which must be discussed in relation to discussions of abortion under health care reform. First, it is essential that such services be provided to all women confidentially. Intra-family confidentiality must be preserved in order to assure that young women, or women in a non-supportive married relationship, can be free to make personal health decisions about unintended pregnancy—as well as contraceptives, STD treatment, and other sensitive issues—without fear of retribution from parents or spouse. The Clinton plan should include an intra-family confidentiality provision.

Second, AMWA is concerned that the Clinton plan's clause allowing any "health professional or health facility" to refuse to provide a given service on moral or religious grounds will disproportionately and adversely impact access to abortion services. If the broad language of this so-called "conscience clause" is maintained, entire populations of women will potentially be denied abortion services unless they have the means to travel—hundreds of miles in rural parts of the country. It is crucial to remember that 83 percent of all U.S. counties do not currently have an abortion provider. The conscience clause must be accompanied by language mandating that all necessary enabling services, such as transportation and child care, be covered if a woman must travel outside her immediate geographical area. Any patient seeking medical services must not be required to expend additional personal funds in order to received covered care.

Third, it has been suggested that a middle ground on this contentious issue can be found by excluding abortion coverage except for those women who purchase an additional rider to the new health plan. Yet proponents of such a proposal are essentially asking women to anticipate an unintended pregnancy, and to consequently pay more for their health coverage. The nature of health insurance is to prepare patients for the unforeseeable, to give them the security to weather a serious illness or accident without fear of financial hardship. To require a woman to use a crystal ball in planning for her health coverage, rather than utilizing available public health data about the widespread need for abortion care, is as medically illogical as it is economically inequitable.

MENTAL HEALTH

AMWA welcomes the Health Security Act's recognition that mental health comprises an essential component of overall health care. The stigmatization and misdiagnosis of mental illness is a burden to our health care system and our populace. Provision of care for the mentally ill and substance-addicted is a patchwork of adequate, comprehensive treatment juxtaposed with inadequate and ineffective programs. In medical plans, both public and private, people with mental illness and substance addictions have been historically regarded as less sick, less disabled, and less deserving of coverage for their care. The plans which do spell out mental health benefits have severe limitations on coverage.

The costs of inadequate mental health care cannot be ignored. Indeed, a recent study published in the Journal of Clinical Psychiatry estimated that mental illnesses such as depression and manic depression—which strike 11 million Americans—exact an annual economic toll of $43.7 billion in suicide, missed days of work, and lost productivity. (The Centers for Disease Control and Prevention estimates the number of Americans living with depression even higher, at 15 million.) These figures do not even take into account the health care costs incurred when patients seek medical treatment for problems which are actually symptoms of depression, such as loss of appetite and sleep disorder.

In addition to these economic considerations, there are the innumerable social problems which arise from lack of available treatment for those with mental illness and chemical dependency. The mentally ill comprise a major proportion of the homeless population—and half of all homeless women and children are fleeing domestic violence. Substance abuse is a treatable illness, and reduction in the demand for illegal drugs and the treatment of alcoholism would take dramatic action in curbing crime, violence, and accidents. A study published early this year indicates that 14 percent of all Americans will be dependent upon alcohol at some point in their lives, and 7 percent during any given year.

Recent research has also shown that women bear a disproportionate burden of mental illness. Women suffer from depression at twice the rate of men, and are more likely to experience anxiety disorders, particularly those related to rape, sexual abuse, and other trauma. Given that two to four million women are battered every year—and that in over half of those homes, children are being abused as well—it is essential that women (and their partners) have access to counseling serv-

ices for the treatment of violence, as well as the prevention of future violence. And while drug and alcohol abuse predominate in men, women—especially pregnant women—are less likely to be accepted in treatment programs for these addictions. Particularly important for women, as I noted earlier, is the range of provider settings which the Clinton plan covers—including inpatient and residential treatment, intensive nonresidential treatment, and outpatient services.

The Health Security Act does not, however, provide mental health coverage which is on par with the latitude or comprehensiveness of the proposal's other provisions. The day/visit limits and the high co-payments (50 percent) required by the plan will prove insurmountable obstacles for many women in need of mental health care. Furthermore, the "collateral services" for family members of those with mental illness or substance abuse should be available even if the ill/addicted person is not enrolled in treatment. Families coping with the illness/addiction suffered by a loved one must have access to the support they need to continue their lives in a productive and healthy way.

Although mental health is often shortchanged in the interest of cost-containment, AMWA urges Congress and the Administration to reassess this perception. The unnecessary hospitalizations, endless outpatient treatment, and exorbitantly-priced addiction treatment centers of the past are being replaced by care which relies upon established outcome guidelines to make treatment decisions. The American Psychiatric Association (APA) and the American Society of Addiction Medicine (ASAM) have developed practice guidelines for all psychiatric disorders and addictive illnesses. And furthermore, increasingly indisputable evidence shows us that many mental illnesses, such as depressive and anxiety disorders, are physical and/or chemical brain disorders, and can be controlled relatively easily with prescription medication.

LONG-TERM CARE

Because women on average live longer than men, they have a particular need for long-term care. It is ironic that although women provide the bulk of the chronic care to our nation's sick—whether as physicians, nurses, hospice workers, health educators, or unpaid caretakers of family—they are often left widowed and without care when they become chronically ill themselves.

Given that long-term care is very much a women's health issue, AMWA is heartened by the Health Security Act's substantive start toward achieving comprehensive long-term care for all. The proposal enables states to provide eligible individuals with a range of services, with an emphasis upon home- and community-based care.

Eligibility for coverage, however, will not apply to all who need care, primarily because the amount disbursed to states will be capped. Thus, individuals will have to meet criteria based both upon a patient's income, and upon her need for aid with activities of daily living (ADL). The legislation currently requires aid with three ADL's, a significant level of disability. Furthermore, cost-sharing is required for those individuals above 150 percent of poverty. Given that women comprise the majority of those below the poverty line, AMWA is concerned that many women in need of long-term care services will be denied care unless these qualifications are amended. And because the program is administered through appropriations to the states, we are concerned that annual political battles, not sound public health policy, will determine the amounts distributed to state coffers.

In addition, AMWA is disappointed that nursing home care is excluded under the proposal, except for those poor enough to qualify for Medicaid under the current health care system.

Finally, AMWA applauds the coverage of prescription drugs under the Health Security Act. Women over age 65 spend approximately $6.5 billion annually on prescription drugs. Yet because the median income of older women is $8,189 (in 1992, compared with $14,548 for older men), the Clinton proposal's premium increase, annual deductible, and copayment requirements will pose significant barriers to the elderly in need of prescription drugs.

CONCLUSION

Congress and the American public have an extraordinary opportunity to include millions of uninsured and underinsured populations in the health care system. The needs of women, comprising more than half of the population and making the majority of health care consumption decisions, must be met comprehensively, sensitively, and equitably. Without full access to a range of guaranteed services, and full autonomy over personal health care decisions, American women will remain on the bottom tier of our two-story health care system. AMWA looks forward to helping this subcommittee, and the entire Congress, level the playing field and win the

quality care that all American women and their families deserve throughout their lives. Thank you.

[Additional material may be found in the files of the committee.]

PREPARED STATEMENT OF SUSAN WYSOCKI

Madame Chairwoman and Members of the Subcommittee, thank you for inviting us to testify today on the needs of women in health care reform.

The American Nurses Association is the only full-service professional organization representing the nation's two million registered nurses including staff nurses and advanced practice nurses. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by working closely with the United States Congress and regulatory agencies on health care issues affecting nurses and the public.

ANA believes that we need a health care system that stresses primary care and prevention and that unleashes the great potential of nurses and other health care professionals to provide these services. Nursing is committed to supporting and implementing initiatives that fully address these key issues. We are very encouraged that many of these issues have been addressed by the President's Health Security Act (S. 1757/H.R. 3600) as well as several other comprehensive health care reform initiatives including Senator Paul Wellstone's proposal and Senator John Chafee's plan.

We are also testifying today on behalf of the American Association of Critical Care Nurses and the National Nurse Practitioner Coalition.

The problems that women uniquely or disproportionately face within our current health care system include: lack of comprehensive benefits, limited access to health insurance, barriers to health care services, limitations on access to a full range of health care providers, gaps in knowledge in women's health research, and an overall male-bias in treatment from the health care system. As nurses, we are acutely aware of these problems in the health care system, both from the perspective of providers as well as from the perspective of the health care consumer—97 percent of all nurses are women. We appreciate the opportunity to testify before you today: Madame Chairwoman, and thank you for your continued leadership and support on women's economic and health issues.

Nursing has a long history of advocacy for women's health. Pioneers in women's health include such nurses as Margaret Sanger, who began her career as a public health nurses on Manhattan's Lower East Side and believed that the elimination of poverty among women would only evolve if women could control their family size. It was from these personal experiences that propelled Sanger into the founding of the modem contraceptive and family planning movement.

Nurses also played a major role in the evolution of maternal and child health. In 1921, Congress enacted the Sheppard-Towner Act—the first Federally funded health care program to be implemented in the United States. Its mandate was to reduce infant and maternal mortality and morbidity by establishing prenatal health centers where expectant mothers were counseled on how to take care of themselves and their children to prevent illness and promote health. The Sheppard-Towner Act also underwrote the costs of sending public health nurses into the homes to teach better health practices in the community. This Congressional legislation was one of the rust examples of identifying women's preventive health needs as a social concern and using public health nurses to meet those needs. By 1926, there were over 8? nurses employed within the Sheppard-Towner clinics. Their main duties were to provide advice on hygiene, encourage breast-feeding, give routine prenatal care, and instruct the midwives how to deliver babies. This early Federal program relied on the skills and training of nurses to increase the self health care skills of women.

WOMEN NEED ACCESS TO HEALTH CARE INSURANCE

For too long women have been set apart and treated as marginal when it comes to accessing the health care delivery system. Currently, 12 million women have no health insurance of any kind and millions more have inadequate coverage. In today's society, to be without health insurance is to be without health care. However, even when women gain access to health insurance, barriers continue to limit access to actual health care services.

The factors that contribute to women's lack of health insurance coverage and therefore, lack of access to health services are many including poverty, a change in marital status or a change in employment. Poor women and near poor women are the least likely individuals to have access to health insurance. There is a high correlation between poverty and lack of health insurance—22 percent of all women

under age 65 with incomes below $15,000 per year have no health insurance. Many women obtain their health insurance as a spouse—through their husband's employment. Changes in marital status such as divorce or widowhood can either cause that insurance not to be available to the spouse, or require that spouse absorb the full cost of the premium for that insurance can be cost prohibitive. If women do receive health insurance benefits through their own employment, changing jobs usually requires a change in health insurance companies, and can also impact on provider availability. Nurses, on the average, have a job tenure of 3 years per employer.

Most Americans obtain health insurance through their employers and this situation disproportionately impacts women. Large differences in earnings, income and work patterns of women seriously disadvantage women's ability to gain health insurance. Almost 60 percent of men have health coverage through their jobs whereas only 37 percent of women have employment based health insurance. Even when women are employed full-time, they are in jobs that are less likely to offer health insurance as an employment benefit than jobs held by men. In addition, more women than men comprise the part-time or seasonal workforce which include jobs that are even less likely than full time jobs to offer health insurance as an employment benefit.

WOMEN MUST BE ABLE TO PAY FOR HEALTH CARE

Access to high quality, affordable health care is not only gaining the ability to have health insurance, but also the ability to pay for health care services. Skyrocketing costs of individual and dependents coverage as well as out-of-pocket costs for health services have made health care unaffordable for many women and their families. Women generally have higher out of pocket costs than men due to their greater use of reproductive and preventive health services. According to a recent report by the Women's Research Education Institute, women account for 69 percent of the over 10 million Americans ages 15 to 44 years who have out of pocket expenditures that exceed 10 percent of their total income. This percentage includes nearly 5 million women who have private health insurance.

Nursing believes that no individual should be denied access to health care on the basis of ability to pay or a change in employment status. Pre-existing health conditions must not be allowed to preclude coverage nor increase health care premiums. Under President Clinton's The Health Security Act, and Senator Wellstone's American Health Security Act (the single payer proposal), families would have a choice of plans from a fee for service model to a HMO with different co-payment and deductible requirements, except for preventive health care which would have no co-payment requirement. Subsidies for health care premiums would exist for families with incomes of 150 percent of poverty and below. Although nursing strongly concurs with the President's proposal that preventive care should be at no cost to individuals and families, we are concerned that some of the co-payments and deductibles for low income families may still act as a barrier to accessing health care services. The median income for American women in 1992 was $10,700. Under The Health Security Act, there are no cost-sharing subsidies for those families with incomes above 150 percent of poverty. It is reasonable to believe that a co-payment of $25 per emergency department visit could be cost prohibitive for a low income family. Every effort must be made to assure that those within 250 percent of the poverty level are assured access to health care services.

Today, Medicaid serves as the primary vehicle for health insurance and coverage for low income individuals, comprised primarily of women and their children. The Medicaid program has been a critical safety net for those at the very bottom of the economic ladder, providing essential health services to poor and near poor families. The programs under Medicaid include not only health services such as prenatal care, but support and enabling services, such as transportation to health centers and coverage of day care facilities. Although Medicaid meets a very important health need in this country, it covers only 42 percent of the poor and uninsured. Under The Health Security Act as well as other legislative proposals addressing health care reform in the Senate, Medicaid is folded into the new scheme of health plans, thereby allowing Medicaid beneficiaries to enroll in the same health care plans offered to the population at large and lessening the detrimental effects of the two tiered system of health care that exists today. All Americans would be entitled to the same benefits package, regardless of economic status. Mainstreaming Medicaid does offer potential for great improvements in access, but certain Medicaid beneficiaries risk losing some of their current benefits. Today, states have the option of allowing Medicaid to pay for enhanced prenatal care (i.e., nutritional counseling/transportation for medical visits) for families up to 185 percent poverty. Under The Health Security Act, such supplemental services would be continued only for Aid To

Families With Dependent Children (AFDC) and Supplemental Security Income (551) recipients which means that near poor families that are eligible for non-cash benefits would lose access to benefits for pregnancy and postpartum services in some states. Issues that impact poor and near poor families are always women's health issues, as women are often the single head of a poverty level family. All efforts must be taken in reforming the health care system to ensure that no poor or near poor family loses health care benefits provided under the current Medicaid system and that access and coverage of health care services is both available and affordable for all families.

WOMEN NEED ACCESS TO HEALTH SERVICES

The Health Security Act takes a major step in the direction of reorienting and restructuring the health care delivery system to ensure that women have access to health services by maximizing the delivery of primary and preventive health care in convenient community-based settings such as at the workplace, schools, day care centers and in the home. In a restructured health care setting, the hospital would serve as the place where serious acute health care needs are met, but other health care sites would be more appropriate as well as less expensive for the provision of preventive and primary care.

One example of this type of community setting is a family health center, located near or at a public school, and utilized to address the health care needs of America's families. These centers would deliver family-focused primary health care that is accessible and interlinked with other components of a community's health care delivery system. Existing primary care clinics and strong public health systems can be expanded to become school based family health centers. The fundamental principles guiding community center care is the emphasis on family, the convenient delivery of primary health care, the utilization of community oriented grassroots institutions (such as schools or worksites) as the health care delivery site and a health care provider role that empowers consumers by increasing ownership of their own health care and exchange of information with health care professionals.

The University of Maryland's School of Nursing has started a non-tradition storefront site for health care called Open Gate was recently opened in Baltimore. This health care facility is staffed by nurses and nurse faculty from the University. Open Gates serves mothers and children who have many unmet health needs, despite the nearby presence of excellent traditional health care in an academic medical center. The health center draws upon the many residents who have psychological barriers or otherwise can not access the use of traditional, medicine-focused health care.

Other health care delivery sites in a restructured health care system must include family planning clinics and birthing centers to meet the reproductive health needs of women. It is important that family planning clinics be a point of entry into the health care system so that young women do not need a referral to be able to access family planning services.

Another important health delivery site that must be incorporated into the reformed health care system is nursing homes, home health care arrangements, and day care centers for the elderly population. Older women are one of the fastest growing population groups in this country, as well as one of the fastest growing poverty populations, and they need access to the most appropriate health delivery setting for their care.

Nursing is examining how to better serve the community in non-traditional health care delivery facilities. Public health nurses in Maryland's Eastern Shore are collaborating more closely with referral sites to establish a more comprehensive, coordinated system of care, without additional resources. These types of care arrangements benefit women who for reasons of family obligations, income limitations, or other reasons face numerous barriers to accessing actual health care delivery services.

WOMEN NEED ACCESS TO A RANGE OF HEALTH PROVIDERS

Women should have the option in a restructured health care system of receiving care from the health care provider of their choice. Providers should include not only physicians, but nurses (including nurse practitioners, certified nurse midwives, clinical nurse specialists, certified registered nurse anesthetists, as well as other nurses), and other appropriate providers. By working to balance an individual's health needs with enhanced self-care capabilities and more accessible provider services, health care can be delivered in a more efficient as well as a more coordinated manner that will benefit women's health.

The role of primary care providers in all levels and arenas of public and private health care planning as well as national implementation of primary health services

through a re-vitalized Public Health System will provide long term cost savings as individuals become less sick and require less expensive care. This process requires, however, rapid initiation of public education programs to increase consumer awareness and responsibility in life style choices and self care capabilities as well as the removal of barriers that restrict the utilization of the most cost-effective quality health care provider. The major obstacles to reform of such health care services are the practitioner limits (i.e., reimbursement, unnecessary supervision requirements, etc.) set by Medicare, Medicaid and other Federal and State laws. The ability of nurses to provide health care services has been continually hampered by a number of artificial barriers that serve to cut the consumer off from access to services provided by these competent and qualified health providers. Factors such as artificially depressed wages, lack of third party reimbursement policies by Federal and state programs and private insurers, limitations of State nurse practice acts, the unavailability of malpractice insurance and institutional opposition to independent nursing practice have had a major negative impact on the ability of advanced practice nurses to fully practice within their educational and training parameters. These barriers generate prohibitive inconveniences for consumers by denying them access to their choice of provider.

The Health Security Act addresses many of the barrier issues for advanced practice nurses such as mandating direct reimbursement for advanced practice nurses under Medicare and overriding restrictive State laws on advance practice nurses scope of practice. However, additional steps are needed to guarantee that the health care delivery system includes quality, cost-effective providers, such as nurses, across a continuum of service sites. To recognize nurses as fully qualified providers in a reformed health care system, Federal pre-emptive measures must be taken to remove professionally unnecessary restrictions on nursing practice. Although The Health Security Act includes an override of restrictive state practice acts, an enforcement mechanism is needed to assure that states comply.

A second barrier that impacts the ability of advanced practice nurses to care for women is the discrimination by individual health plans against non-physician providers. For example, health plans often arbitrarily exclude advanced practice nurses from their panels or managed care networks. If they do admit nurse practitioners, in some cases the health plans or individual hospitals do not extend hospital admitting privileged to the nurse, thereby restricting their ability to delivery patient care. In a reformed health care system, health plans, whether Federal, state, or private, must not be allowed to discriminate against nurses either by excluding nurse providers' services from coverage or by preventing nurse providers from participating in the health plans. Many women's health nurse practitioners have found themselves arbitrarily excluded from managed care plans, despite the fact that they offer quality health care services at cost-effective rates and with high patient satisfaction. This potential discrimination against providers not only impacts nurses, but all other nonphysician providers as well as health providers of color, and providers that serve specific populations such as the gay and lesbian community.

Nursing urges that antitrust laws must be strengthened in the health care arena to ensure that health providers are treated equitably. Artificial barriers of practice must be removed by clearly articulating what those inappropriate barriers to practice are and compelling all government and business entities to treat all health providers in accordance with the legal scope of practice.

In addition to these barriers, advanced practice nurses (i.e., women's health nurse practitioners) must be eligible for reimbursement under any fee for service plan. Under current law, nurse practitioners and clinical nurse specialists are reimbursed under Medicare in rural areas, and only a limited category of advanced practice nurse practitioners (Pediatric Nurse Practitioners and Family Nurse Practitioners) are reimbursed under Medicaid. Direct Medicare and Medicaid reimbursement must be provided to all advanced practice nurses without distinction as to the geographic area or category of advanced practice nurse and without regard as to whether an advanced practice nurse is associated with or practices under the supervision or direction of another health care provider.

It is important to note that many women receive their care from advanced practice nurses. From the OB-GYN nurse practitioner operating a women's wellness center, to the clinical nurse specialist staffing the family planning clinic, to the certified nurse midwife who delivers babies at the birthing center, to the geriatric nurse practitioner in the nursing home, these providers play an integral role in the delivery of health care to women.

Nursing care has been shown not only to be highly satisfying to patients, but also cost-effective. An example of the effective care provided by certified nurse midwives (CNMs) is documented in a recent study that found that nurse-midwives use more natural and less invasive labor and delivery procedures resulting in less physical

trauma to the mother, a shorter hospital stay, fewer premature deliveries, and babies which are as healthy as those delivered by physicians.

WOMEN NEED A COMPREHENSIVE BENEFITS PACKAGE

A critical cornerstone of reforming the health care systems is ensuring that all individuals have access to and coverage of a comprehensive set of health benefits. ANA believes that a broad standard must be adopted that requires coverage of all services which are necessary or appropriate for the maintenance and promotion of health. Comprehensive benefits and health services include a full range of preventive services, primary health care services, reproductive health care services, long term care services, as well as acute care and emergency health services.

Many current health plans including Medicare do not assure that women's basic health needs are met. Certain diseases and conditions are unique to or more prevalent among women and women must be assured access to affordable treatment for those conditions and diseases. For example, one out of nine women will be diagnosed with breast cancer and over 45,000 women will die from breast cancer this year. Regularly scheduled mammograms at no cost to the woman must be readily available. Women experience osteoporosis at a far greater rate than men, with one out of three women over the age of 65 years developing the disease. Women need access and coverage of bone screening/measuring exams to help them avoid hip fractures and other bone problems that can result in costly long term nursing home care. Depression is more prevalent in women with a rate of twice that of men. One in four women will experience a major form of depression some time in her life. The interaction of negative life experiences (i.e., poverty, abuse) can often contribute to the onset of depression. A comprehensive mental health package of benefits must be included for women of all ages in any health care reform standard benefits package in order to address women's mental health needs as well as physical and biological concerns. Preventive health care can not ignore such simple undertakings as screening for domestic violence. Violence against women, a long-ignored threat to women's health, is the single major cause of emergency department visits by women. By performing a simple screening in the emergency department as well as in prenatal visits, many women can be helped to find the social support services they need to leave a violent situation.

A comprehensive benefits package is one which includes an emphasis on clinical preventive care, i.e., screening, immunizations as well as counseling services. An important component of The Health Security Act is that preventive health services not include copayments which may act as a deterrent for women to utilize them. Nursing urges this Committee to consider the inclusion of family planning as a preventive health care benefit in order to encourage women to access contraceptive services. In addition to family planning, it is essential that screening such as pap smears, mammograms, pelvic exams, screening for sexual transmitted diseases, domestic violence screening, prenatal screening, and other routine screening that benefit women are included in any benefit package.

The inclusion of preventive services is especially critical for minority women. Minority women without health care insurance or with low incomes are less likely than white women under our current health system to receive preventive health services. For example, the majority of black and Hispanic women (57 percent) do not receive preventive services, while the majority of white women do. There is evidence that the lower a woman's income, the less likely she is to receive preventive health services. ANA was awarded a cooperative agreement from the Centers for Disease Control and Prevention (CDC) for the a project addressing breast and cervical cancer in low income African-American women. This project is part of a comprehensive national program which was established by the Breast and Cervical Cancer Mortality Prevention Act of 1990 which directs the CDC to make grants to state health departments to establish programs to prevent mortality from breast and cervical cancer. The project will establish a national education program aimed at teaching undergraduate nursing students, advanced practice nursing students and nurse clinicians how to teach low income African American women about breast and cervical cancer screening practices.

Nursing believes that education and counseling are the most effective forms of preventive health care available to a health provider. The key to prevention is influencing an individual's own health-related behaviors through education and counseling. A recent survey on the prevention practices of primary care providers, however, indicates that many primary care providers do not counsel on preventive health care. There are many reasons cited by these providers for their lack of delivery of preventive care including uncertainty about who should be counseled and screened, how often these questions should be asked, and reimbursement for these health care

services. For example, inquiry about alcohol consumption and other drug use ranged from 23 percent to 63 percent; inquiry about diet and nutrition and formulation of a plan ranged from 15 percent to 53 percent; and mammography screening ranged from 53 percent to 85 percent. Generally, the rates for nurse practitioners on these inquiries and screening were higher than for some other practitioners, but there is still room for a lot of improvement. There are many reasons for these low rates including by including preventive health care in a standard benefits package, practitioners will be reimbursed in public and private health plans and the health care system will begin to focus on wellness and prevention instead of the illness driven model that now dominates the system.

In addition to the inclusion of preventive health services, counseling must be a central aspect of women's health care. The U.S. Preventive Services Task Force has found that teaching and counseling interventions are of more value to patients than diagnostic testing. They predict that this finding suggests a new paradigm in defining the responsibilities of the primary care provider. For example, counseling on the use of a seat belt can literally save lives. Motor vehicle injuries affect nearly 4 million individuals per year and are a leading cause of death for individuals, ages 5 to 44 years. Nurses have a long history of counseling patients on health care issues from family planning to nutrition to factors that impact reproductive health cancers to prenatal care. Nursing counseling services are already part of most state nurse practice acts, and must be available to all individuals in community based settings to truly re-orient the health care delivery system.

Under The Health Security Act, abortion is presumed to be provided as a covered service under the category of services for pregnant women. It is also assumed that Medicaid beneficiaries (i.e., low income women) will also have full access to these reproductive health services because they will be folded into the health plans offered by each regional alliance. ANA has long advocated that all populations of women must have access to reproductive health care services, regardless of their income. ANA has consistently signed on to amicus briefs before the Supreme Court on removing barriers to reproductive health services arguing that states should not be allowed the flexibility to restrict women's access to abortion services. Under our current system, most women who have private insurance do have access to and coverage of abortion services. Health care reform should not be used to take any health care benefit away. ANA supports freedom of choice on the basis that each individual has the right to make decisions about personal health care based on full information and without coercion. If the state limits the provision of such information to the client, an unethical and clinically inappropriate restraint will be imposed on the provider and provider client relationship will be jeopardized. It is for these reasons that ANA advocated the necessity of removing the so-called "gag rule" that prohibited Title X counselors (many of whom are advanced practice nurses) from providing information to their clients on all information concerning their pregnancies.

Nursing urges this Committee to ensure that a standard benefits package that meets the needs of women is included in the health care reform proposal. The components of the benefits package should not be left to a National Health Board. In addition, the health services included in the standard benefits package should be provided by a variety of health professionals licensed or otherwise authorized by the State to deliver such services.

WOMEN'S WORKFORCE ISSUES IN A CHANGING HEALTH CARE SYSTEM

Several workforce issues associated with health care reform may disproportionately impact women—specifically women who work in the health care service arena—whether as a nurse, hospital technician, or insurance adjuster. Job displacement is anticipated as the health care system moves from one focused on acute care to a system that emphasizes preventive and primary care. As the majority of employees in the acute care setting are women, this displacement of workers will disproportionately impact women. Therefore, provisions to assure a smooth transformation to a new system of health care and address the training and re-employment needs of women workers need to be addressed in health care reform proposals. Health care reform could accelerate the shift to a community-based system of care which will result in new jobs in primary, preventive, critical and community care arenas. Nursing supports the inclusion of a National Institute for Health Care Workforce Development in the President's health care reform proposal. We believe that a body to analyze the workforce needs of a new health care system will be critical during this time of transition. Under The Health Security Act, The Institute would be comprised of representatives from health care institutions, labor unions, educators, and consumers—all of whom have a stake in creating a health care system that works.

Nursing looks forward to working with Congress to develop a re-employment plan for dislocated workers. All nurses (as well as other women displaced in the evolving health care workplace) must have access to the re-employment programs and benefits designed to assist dislocated workers. In addition, any re-employment plans must not exclude part-time employees. Women are disproportionately included in the part-time workforce. Approximately one-third of all nurses work part-time. These nurses may be attending school or caring for young children, but their income is critical to the support of their families. Nursing is pleased to see that support services, such as child care, are included as an appropriate expenditure of funds in The Health Security Act and in the drafts of a national reemployment plan.

DISCRIMINATION AGAINST WOMEN IN THE HEALTH CARE SYSTEM MUST BE ABOLISHED

Studies show that traditional medicine has not treated women patients as equals; data demonstrate that when a woman with a heart attack is admitted to the emergency department she is less likely to receive aggressive treatment than a man admitted with similar symptoms. Women often state that their health complaints are not taken as seriously by their provider as when a man presents his physical complaints. It is not unheard of for a provider to suggest to a woman patient that her physician problem may be one of imagination or at least exaggeration. Providers must be educated to deliver health care services that are appropriate and individualized to each patient's need. Although women differ from men both metabolically and hormonally, it is important to assess whether they are being treated appropriately. Sex role stereotyping in the delivery of health care services must be eliminated through both education of providers and use of treatment protocols that recognize the needs of both men and women.

WOMEN'S HEALTH RESEARCH NEEDS ARE IMPORTANT TO HEALTH CARE REFORM

Scientific research continues to be needed in every aspect of women's biological lives—from infancy through the later years. Research is needed to provide increased understanding of women's health related to various stages of life. Significant information about women in specific disease areas continue to be lacking despite recent Congressional efforts to increase funding for Federally sponsored research programs and mandating the inclusion of women in clinical trials. Focus continues to be needed on the gender and ethnic differences in the biology and physiology of diseases. In addition, a gender gap in the research on the normal growth and development patterns of women is evident. By increasing this research, the understanding of disease patterns will also increase.

The special health risks of minority women, many of whom are vulnerable to high blood pressure, strokes, and HIV disease, can not continue to be ignored. As gender-specific health research is critical, so is research that identifies the concerns of and treatments for women of color. For example, research is needed to determine what factors race plays in the incidences of breast cancer.

In health care reform, it is critical to note the continuing research needs of diseases and conditions that disproportionately impact women. The Health Security Act emphasizes the need for outcomes research to better serve the health needs of the nation. Outcomes research, however, must pay attention to the physiology of women. ANA urges this Committee to ensure that any health care reform proposal includes an emphasis on women's health research.

REPRESENTATION OF WOMEN IS NECESSARY IN A REFORMED HEALTH CARE SYSTEM

Women, including women of color, should be appointed to all Federal, state, and local government boards and policy advisory groups in order to achieve a balanced representation of health care consumers at all levels of government and within all public and private delivery systems as a matter of good public policy.

CONCLUSION

ANA wishes to thank the Chairwoman for holding this critical hearing today on the needs and concerns of women's health care in reforming the health care system. We look forward to continuing to work with you on these issues as the health care reform debate moves forward.

Prepared Statement of Janet Kurland

Good Morning. My name is Janet Kurland. I am a social worker and I am Assistant Director of Older Adult Services with Jewish Family Services in Baltimore, Maryland. I am here today representing the National Association of Social Workers

(NASW). NASW represents 147,000 professional social workers, two-thirds of whom practice as primary care providers in health and mental health care settings.

I am delighted to be here to participate in today's hearing on women's health care needs through health care reform. Because time is limited, I would like to focus on a few specific areas that have particular relevance to my field of social work practice. These areas include the need for: comprehensive long-term care services; comprehensive mental health care and substance abuse treatment services; case management, as an integral service in health and mental health care delivery; and availability of professional social work services to meet the health and mental health care needs of older women. In outlining these issues, I will use the President's Health Security Act (S. 1757) as my frame of reference.

Before talking about these four critical needs in health care reform, I'd like to make a few comments about NASW's position on health care reform. NASW has a longstanding history of advocating on behalf of universal coverage to comprehensive health, mental health, and long-term care services. In 1990 the NASW Board of Directors approved the NASW National Health Care Plan, a comprehensive single-payer approach to health care reform. This plan is embodied in S. 684, the National Health Care Act of 1993, that was introduced by Senator Daniel Inouye (DHI) in the 103rd Congress, and represents the best thinking of the social work profession regarding how to deliver comprehensive care to all Americans in a way that the nation can afford. NASW has also endorsed S. 491, the American Health Security Act, introduced by Senator Wellstone.

NASW believes that the single-payer approach is the best means of providing the kinds of services that I want to talk about today—in part, because the single-payer system provides the efficiency to be able to afford universal coverage to these critically needed services. Because I will be using the Clinton bill as my frame of reference in discussing these needed services and will highlight certain limitations in the President's proposal, I want to be very clear that NASW supports the Administration's efforts to boldly move toward health care for all. Additionally, NASW supports the Health Security Act's principles to ensure universal coverage, require all employers to contribute to the cost of health care, establish a comprehensive benefits package, enact systemwide cost controls, and allow states to implement single-payer health care systems. We believe these elements are essential to enactment of meaningful health care reform.

I'd also like to point out that with the exception of the single-payer proposals, the President's Health Security Act is the only other health care reform bill that actually addresses the services I'll highlight today. Unfortunately, I think that the limitations in the President's proposal have come under such intense scrutiny that the public is unaware that most of the other health care reform proposals don't contain comprehensive benefits at all.

LONG-TERM CARE SERVICES

In brief, overall advantages in the President's proposal for seniors' health care coverage include: prescription drug coverage for Medicare beneficiaries; establishment of a new home and community-based long-term care program; prohibition on balance billing in Medicare; and significant improvements for seniors in reducing certain cost sharing requirements, eliminating some gaps in coverage, addressing the insecurity faced by early retirees, and providing additional regulation of the supplemental market.

Additionally, we are very pleased that the Health Security Act contains a national research agenda that includes attention to: chronic and recurrent illnesses as a priority area for research and mental disorders among the elderly and their caregivers.

For older women, the proposal's long-term care benefit is of particular importance and contains significant limitations.

> Nursing home coverage is not included in the benefit and has particular relevance to older women who represent the majority of nursing home patients.
>
> Eligibility for the home and community-based long-term care benefit is based on a beneficiary's need for assistance in performing 3 activities for daily living, a particularly rigid standard, and burdensome for older women living alone who need the service and for older women who serve as caregivers for an elderly parent or spouse.
>
> Additionally, there is not a defined benefit package for the home and community-based care benefit, so it is uncertain whether older women will actually have access to the kinds of services they need, such as respite care for caregivers.

Having focused on the limitations in the Clinton proposal, I want to emphasize again that the President's proposal is one of a few in which these needs are ad-

dressed at all. In some of the health care reform bills, not only is long-term care non-existent, but the proposed dismantling of Medicaid threatens the continued role of Medicaid as the last resort or "safety net" for nursing home care coverage.

MENTAL HEALTH/SUBSTANCE ABUSE COVERAGE

NASW believes that equitable coverage for mental health care and substance abuse treatment is critical within a reformed health care system. Given such problems as the high rate of suicide among the elderly, the relationship between emotional stresses and aging, the increase of chronic conditions and their impact upon mental health of the elderly population, and the prevalence of alcohol and other substance abuse problems in our older population, we believe the benefit is particularly important for senior citizens. Attention to the mental health needs of individuals and their families with chronic and/or life-threatening illnesses is very important. If they are not addressed, the biopsychosocial needs of individuals with medical problems may interfere with the medical care treatment plan, may trigger the use of unnecessary medical care, and may result in inappropriate hospitalization or institutionalization.

The President's Health Security Act contains obvious holes in providing real access to a full range of appropriate mental health and substance abuse services. Nonetheless, the proposal provides universal coverage to the available services and calls for parity between mental health/substance abuse services and physical health care services in the Year 2001. While there are very apparent limitations in coverage, there is a most definite recognition on the part of the Administration that mental health care and subtance abuse treatment services are critically needed among the American populace. With the exception of the single- payer proposals and the President's bill, comprehensive mental health care and substance abuse services are simply not on the legislative map.

The Health Security Act does not make improvements to the Medicare Program's mental health benefit. Consequently, older women who will continue to utilize Medicare will also continue to experience the limititations of the Medicare mental health benefit. The primary limitations in this Medicare benefit include the 50% consumer coinsurance requirement for outpatient mental health care services and the 190-day lifetime limit for inpatient hospital care.

Limitations in the Health Security Act's mental health/substance abuse benefit that will particularly affect older women who are beneficiaries of the program include:

Financial barriers to access for low-income and middle income individuals for outpatient psychotherapy services, as well as for intensive non-residential treatment services that extend beyond sixty days (in each of these cases the beneficiary is expected to contribute a 50% coinsurance rate for fee-for-service plans or a high copayment for each managed care visit.)

limited inpatient and residential services, compounded by the requirement that consumers "trade off" their inpatient days in order to receive access to intensive non-residential treatment services

Inappropriate services to people who are dually diagnosed as having a substance abuse disorder and a mental illness (Unfortunately, individuals in this category may quickly exceed the limits in the interim benefits package because the limits on services apply to both benefits.)

CASE MANAGEMENT

Case management, or care coordination, is a service that NASW believes to be essential to delivering quality health, mental health, and long-term care services. For individuals with chronic and/or multiple care needs, we believe case management should be made available at the point of entry to the health care system.

While case management, or care coordination, is referenced in the Health Security Act, NASW believes that every effort should be made to make this essential service more broadly available. The following are additional clarifications regarding case management:

Case management is particularly appropriate for consumers with multiple and costly health and mental health problems, including individuals using long-term care services.

Case management can save money, because it will ensure that a patient receives the care and services they need, when first seen, to achieve the highest level of recovery and/or functioning and, therefore, minimize repeated treatments and/or hospitalizations and the development of secondary problems.

Case management services should be used to ensure that all necessary and appropriate biopsychosocial services are being delivered, coordinated and mon-

itored to maximize health and the ability to function independently. Care coordination can be critical in helping to ensure a continuum of care, especially for consumers moving from one level of care to another, such as from a hospital to home or community-based services.

Case management can be provided by a qualified individual provider or by a multidisciplinary team of providers. There are a number of non-physician providers, such as social workers, who are trained as care coordinators or case managers. Case managers should have the skills to develop and monitor care coordination plans, including the evaluation and recommendations for appropriate treatment services done in cooperation with patients and other providers; undertake transition management between inpatient facilities and community-based services; identify and arrange for appropriate enabling services; and oversee and ensure quality and effective utilization of services.

Case managers should work closely with primary care providers. In a staff/group model HMO, case managers should be on staff, and available to work with the primary care providers. Nonprofit private or public care coordination agencies could also be established to serve fee-for-service physicians, health care facilities, PPO providers, and community-based health programs and clinics.

AVAILABILITY OF CLINICAL SOCIAL WORK SERVICES IN HEALTH AND MENTAL HEALTH CARE

As a social worker, I also wish to urge your support for the recognition of clinical social workers as primary care providers in health care reform. Clinical social work is defined as a "licensed health care profession" in both the Medicare and Medicaid statutes. Clinical social work is also recognized as a health profession in Title VII of the Public Health Service Act, which acknowledges the primary care functions of social workers who have received a graduate degree and specialized training in health or mental health care. Among clinical social work services in health care are assessment, diagnosis, care planning and coordination, treatment, education, consultation, evaluation, and client-centered advocacy.

Clinical social workers practice throughout the nation's health and mental health care delivery systems and provide approximately 65% of the mental health services in the country. Indeed, in some counties the only licensed mental health care professional is a clinical social worker. All but one state in the nation legally regulate social workers through licensure or certification. Thirty-two states have enacted laws that mandate reimbursement for clinical social workers by insurance plans that offer mental health care coverage.

Clinical social workers are recognized as independent providers of outpatient mental health care in all federal statutes that authorize this care (Medicare, the Federal Employee Health Benefits Program, and the Civilian Health and Medical Program of the Uniformed Services). All of these programs authorize clinical social workers to diagnose and treat mental illnesses, and all of these programs prohibit any requirements of physician referral or supervision. Additionally, clinical social worker services are defined, by law, as within the core benefits that may be provided by rural health clinics and all federally qualified health centers.

For the most part, the President's Health Security Act avoids specific reference to nonphysician health care providers, although the bill's definition of "health professional" would accommodate the recognition of clinical social workers. Additionally, the bill includes a provision to preempt state scope of practice laws that arbitrarily limit the ability of nonphysician providers to deliver services. The bill also specifically maintains state vendorship or freedom of choice laws for fee-for-service plans. A number of service delivery improvements are included in the bill that could lead to increased practice opportunities for social workers, including the recognition of the importance of case management, health promotion and education, and school-based clinic services.

We believe improvements should be made to the Administration's bill in recognizing professional social workers' role in health care reform in the following areas:

Adding clinical social worker to the list of essential community providers that is identified in the bill.

Requiring each health plan to provide a sufficient mix of providers and specialties and aappropriate locations to provide access to professional health services.

Adding clinical social workers and other nonphysician providers to the various Title III programs that are designed to promote primary care and ensure that primary care providers are available in underserved urban and rural communities.

Additionally, we recommend that:

Title III's provision for grants to states for core public health functions include direct health services where these services are not routinely available or assured.

Core health functions should also include such enabling services as transportation, community and patient outreach, patient education, translation services, non-medical case management, social work services, the provision of child care during clinic visits, and home visiting services.

Local and state public health care entities that are currently providing direct health care services be automatically certified as an essential community provider.

Senator Mikulski, some years ago I had the opportunity to present testimony before you on the need to enact changes in the Medicaid Program to prevent impoverishment of a spouse when their husband or wife was forced to enter a nursing home. I am so thankful for your efforts in enacting that change. It was critically needed by so many of my clients. I wish you success in this endeavor as well.

On behalf of NASW, I wish to express my association's willingness and interest in working with you and other members of this committee to enact meaningful health care reform legislation.

Statement of Dr. Dava F. Gerard

Madame Chairwoman, I am Dr. Dava Gerard, a breast surgeon in private practice for fourteen years in Orange County, California. I want to take this opportunity on behalf of the Komen Foundation to thank Senator Mikulski for her energetic efforts for women's health and in the fight against breast cancer. I am testifying on behalf of the Susan G. Komen Breast Cancer Foundation, a thriving vertically-integrated organization that works at the national, state and local levels to eradicate breast cancer as a life-threatening disease by advancing research, education, screening and treatment. Founded in 1982 by Nancy Brinker in memory of her sister Susan G. Komen, the Foundation is a national network of volunteers working through local chapters and RACE FOR THE CURE events now in 48 cities, representing 30 states and the District of Columbia. Central to Komen's program is meeting the needs of the underserved, minorities and those least able to access health care.

In my testimony today, I will present my own review of the scientific evidence upon which the National Cancer Institute based the decision to eliminate its mammography guideline for women 40 to 49, and will briefly summarize my professional judgment regarding the benefits of mammography screening for women in this age category. I will also highlight the efforts of the Orange County, California Chapter of the Susan G. Komen Breast Cancer Foundation to fight breast cancer.

VALIDITY OF SCIENTIFIC TRIALS CONSIDERED BY NCI IN MAMMOGRAPHY GUIDELINES REVIEW

Eight randomized clinical trials, including the National Breast Screening Study ("NBSS") of Canada, were reviewed by the NCI Workshop on Breast Cancer Screening in its effort to determine if routine screening mammography resulted in a significant reduction in mortality for women under the age of 50. The non-Canadian controlled studies suffered from serious shortcomings. These studies lacked prospective trial design and included insufficient numbers of 40 to 50 year old women to glean statistically significant information on this age group.

Moreover, each of the randomized studies were subject to serious deficiencies. The HIP trial used unquestionably obsolete mammographic equipment of the 1970's. The Swedish trials used only single view mammography (known to miss 10% of breast cancers), provided screening at two year intervals (instead of one), and did not include a clinical breast exam. The Edinburgh trials were marred by poor compliance (only 60% of the women in the screened group had an initial screening mammogram), technical problems in their early studies, and only biannual screening. Additional concerns that mammography experts voiced about these studies were (1) the delays in investigating mammographically suspicious lesions, (2) the uncertain ascertainment of the control group deaths, and (3) major randomization problems.

The Canadian Study, or NBSS, has many significant limitations that have been de-emphasized by the Breast Cancer Screening Workshop, NCI and the press. A major design flaw was the lack of blind randomization of women into screening and control groups. Symptomatic women were permitted to participate and were assigned to the control or screened groups after clinical breast examination. Women with advanced breast cancer were assigned more frequently to the screened group. Thus there was a very high initial incidence of advanced cancers in the screened group, virtually guaranteeing an excessively high mortality rate in the screened

group from the very start of this study. The control group had an unexpectedly high survival rate of 90% as compared to an expected rate of 76%. With this combination of high mortality rates (because women with advanced cancers were placed in the screened group) and unusually low mortality rates in the control group, there would have to be almost no breast cancer deaths in the screened grouping in order to demonstrate a statistically significant mortality reduction in women who were screened.

A second major design flaw in the Canadian study was that the trial did not take into consideration women who "crossed over", that is, women who were counted as members of the control group but who received mammograms outside of the trial. (In another of the 8 studies relied upon by NCI, the Malmo study, 35% of women ages 40-50 in the control group had mammograms outside the study.) Additionally, the quality of the mammograms in the Canadian NBSS has been questioned because there was no special training for either the radiologists or the technologists. Some 5% of the mammograms in years 1-4 were externally reviewed and were considered poor or unacceptable. An internal review by the NBSS project's reference radiologist showed problems with interpretations in that 42% of interval cancers were seen retrospectively and 17% of screening detected cancers were seen on mammograms taken 2-5 years previously. Furthermore, 25% of women with mammographically suspicious masses, for whom biopsy was recommended, did not undergo tissue diagnosis. This raises the question whether a delay in diagnosis could account for some of the excess mortality.

Given the serious limitations in study design and clinical research which distinguish the clinical trials reviewed by the NCI Workshop on Breast Cancer Screening, I question the appropriateness of retreating from the screening guideline for women 40 to 49 without scientifically conclusive evidence. In 1989, the NCI and twelve organizations reached a consensus that women between ages 40 and 49 should be screened for breast cancer by mammography. Yet in eliminating the guideline the NCI made a unilateral decision, without the agreement of the breast cancer community. Moreover, in the intervening years between the adoption of NCI's original consensus guideline and its recent decision to retreat from its screening recommendation for women 40 to 49 nothing has changed! No new studies support this change.

BENEFITS OF MAMMOGRAPHY FOR WOMEN UNDER 50

In the United States, approximately 29,000 white women and 4,200 black women between the ages of 35 and 50 will be diagnosed with breast cancer each year. The American Cancer Society estimates are that about 30,000 women ages 40 to 49 will be diagnosed with breast cancer in 1994, and 30,000 in the 50 to 59 age group. Other estimates are that 6% of breast cancers occur in women under the age of 40, and 16% occur in women between 40 and 50. This incidence rate is not insignificant. Nor are the lives of the women diagnosed with breast cancer who are under 50. Any of these women could be our sisters, daughters, wives, friends, or even ourselves.

What is the strongest case that could be made that mammography screening benefits women who are 40 to 49 years old? The findings are at best inferential. Though we lack a scientifically conclusive answer, the inferential data must not be ignored! Four of the five studies with ten-year follow-up show approximately a non-statistically significant 20% reduction in breast cancer mortality in women ages 40 to 50. There is intermediate data from both British Columbia and the University of California at San Francisco that substitutes strong predictors for mortality, for example, tumor size and involvement of lymph nodes. In both studies the benefit of mammography is equal in the 40 to 50 year old woman and in the 50 to 70 year old woman.

The repercussions are enormous of the NCI's decision to eliminate its recommendation that women 40 to 50 receive mammography screening. The ongoing public debate has caused considerable public confusion among women and their physicians. Sadly, this much publicized change in screening guidelines creates even greater disincentives to those women who we know conclusively will benefit from mammography.

The Susan G. Komen Breast Cancer Foundation and other public and private organizations have fought over the past decade to educate women over 40 about the importance of mammography screening and breast health. Much time, effort, energy and money have been spent to break down barriers to mammography screening, especially for medically underserved women. With the change in the NCI guidelines and the resulting confusion, these barriers are being raised again. I fear we will see an increase in breast cancer mortality rates as women once again retreat from screening programs because of fear, because their insurance companies now have an excuse to deny coverage, and because health care planners under strict economic scrutiny have been pressured to advocate delay in screening in young women until we accumulate a statistically significant number of young women dead from breast

cancer. I take care of these women and their devastated families. I know the suffering women and their kids who valiantly have formed support groups like Komen Kids and Karen's Kids, which I describe at the end of my testimony. These are living, breathing people. They are not statistics to me; their suffering is very real.

As a clinician, I have much first hand experience in the enormous tragedy of this disease, but I also have much experience in creating programs designed to meet the needs of our women and their families and the community in which we all live. I fear that we have allowed individuals, "experts", to take a very one sided look at this screening issue. I fear that it will be the mammographers, breast surgeons, oncologists, radiation therapists, breast cancer support leaders, hospice professionals, children and families who will be witness to the grave error of eliminating consensus guidelines, long before "definitive" studies are completed and the statisticians have run the numbers again.

I ask this Subcommittee to take a balanced look at this screening issue and decide that the lives of our 40 to 50 year old women are worth protecting, even before the studies have reached statistical significance.

STUDY DESIGN ISSUES

We cannot wait ten or more years to determine if young women will benefit from state-of-the-art screening mammography. Case control studies need to be investigated, and if these studies are not appropriate, then we need a randomized prospective controlled study designed with adequate numbers of women using state of the art technology to evaluate the optimal periodicity of screening in relation to age, the relative utility of clinical breast examination and breast self-examination. Areas of research should include feasibility of digital mammography, large data banks, stereotactic fine needle and core biopsy. We need to stop pretending that many of these issues related to screening are not economically based. Research should focus on how best to deliver high quality screening programs in a cost efficient manner.

PHYSICIAN TRAINING ISSUES

In the United States, our physician base is not well trained in quality clinical breast examination. Studies have documented that the average length of a breast examination is 1.83 minutes and that 75% of breast exams fail to use two positions. In women 40 to 49, clinical breast exams identify 10% to 25% of the breast cancers, while combined mammography and breast exam identify between 36% and 53%. The Canadian Study consistently documents superior clinical breast examination as compared to other studies. It is clear that mammography and quality clinical breast examination are complementary screening procedures; one does not replace the other.

We know that most women, regardless of age, will be seen by a physician in any given year. We must start training our medical students, physicians and nurses to perform competent quality breast examinations. First, we must develop programs that will effectively provide this instruction. Second, the Congress should consider proficiency certification in the basic clinical examination, much like the American Heart Association certifies basic life support proficiency.

Our primary care physicians need to be convinced that knowing how to conduct proper breast examinations and to understand mammograms are as important as how to understand chest x-rays and listen to lungs. We need to learn how to motivate our physicians. We should have done this a decade or two ago. In this decade, we will have 1.5 million women diagnosed with breast cancer and 500,000 women will die from this disease. There are plenty of opportunities to learn to perform a quality breast examination or understand a mammogram report. There is not a moment—or another life—to lose.

ORANGE COUNTY CHAPTER OF THE SUSAN G. KOMEN BREAST CANCER FOUNDATION

As a breast surgeon, I speak frequently to community and professional organizations about the importance of early detection. I pride myself in maintaining a sensitivity to patient needs. Yet became very apparent to me several years ago that the most challenging breast cancer problems occurred outside my operating room. (This is a tough statement from a surgeon.) Three years ago the Orange County, California, Chapter of the Susan G. Komen Breast Cancer Foundation was organized by several caring and committed volunteer breast cancer health care professionals, inspiring and energetic breast cancer survivors, and resourceful and experienced community leaders. Our very successful 1992 and 1993 Orange County RACE FOR THE CURE raised $500,000 through corporate sponsors, pledges and entry fees; 25% of the funds were our community's contribution to the National Komen Breast Cancer Research Fund, and 75% remained locally to fund our Orange County projects. Our

chapter's collective sensitivity to breast cancer issues allowed us to develop programs rapidly and effectively, many of which became nationally available within the first year.

One example is the idea developed by 12 year-old Jon Wagner-Holtz whose mother was diagnosed with breast cancer. Jon came to us with a proposal for a children's friendship network, recalling: "When my mother got breast cancer, my mother got treated, but really my whole family got breast cancer". Jon helped organize Komen Kids, a support program for children with a parent with cancer. The program rapidly attracted several hundred young members. After the death of our first Komen Kids' mom, 42 year-old Karen, at the suggestion of her nine and twelve year old sons, a special grievance group, Karen's Kids, was added. Several Komen Kids programs have already sprung up around the country to meet this previously unaddressed need.

To explore the psychosocial issues of breast cancer, our Komen Chapter underwrote a professional interactive drama, EVERY PART OF ME, produced by STOP-GAP and performed in board rooms, conference centers and cafeterias in corporations, clinics and community centers throughout Southern California. Our national touring multimedia museum exhibition focusing on breast cancer, "MEMORIES, MILESTONES AND MIRACLES," visually documents the physical and psychological challenges of breast cancer as seen through the eyes, hands and minds of noted artists and poets.

Although this is just a sampling of programs that we developed in order to resolve unmet needs, the project of greatest interest today is our Orange County Komen RACE FOR THE CURE Breast Cancer Early Detection Program which provides language-appropriate breast self-examination instruction, clinical breast exam and ACR-approved screening mammograms to women of limited resources over the age of 40. We have just completed our 1000th screening. Approximately 50% of our screenees are under age 50. Of the 8 women identified with breast cancer, 3 were in the 40 to 49 age group. One woman had pre-invasive (in situ) breast cancer; one woman was identified by mammography only, and one woman had a breast cancer that was readily palpable once the mammographic abnormality was seen.

CONCLUSION

Thank you for your time and attention as we all try to compress hundreds of hours of reviews on this critical issue into a few short minutes. Madame Chairwoman, you and your women colleagues in the Senate are playing a very critical role in the lives of 40 to 50 year-old women. I am sure that you will consider this fact as you weigh the testimony that you have heard today. Please help us continue to advance compliance in our breast cancer early detection programs so that we do not have to take two steps backward in the hope of taking one step forward.

For our part, The Susan G. Komen Breast Cancer Foundation supports President Clinton's commitment to health care reform. We will work with you and other members of the House and Senate to provide mammography screening coverage for women under age 50 as part of the health care reform legislation. And, we will highlight the fine work you and your colleagues are doing on breast cancer issues during the Minority Breast Cancer Awareness Day Breakfast of Champions and Symposium with the Congressional Black Caucus and the Congressional Hispanic Caucus on April 28.

Finally, I want to thank you for this opportunity to testify, and I urge you to join us in RACE FOR THE CURE for breast cancer. One way you can do so is to urge all your colleagues to participate in our 5th Annual D.C. RACE on June 18.

Thank you.

PREPARED STATEMENT OF JUDITH DESARNO

Madame Chair, members of the Subcommittee, my name is Judith DeSarno and I am President and CEO of the National Family Planning and Reproductive Health Association. I am pleased to have the opportunity to submit this testimony on behalf of NFPRHA which represents the full spectrum of publicly-funded family planning providers, including over 4,000 clinics serving more than four million women and adolescents annually.

While the outcome of the health care reform debate is unclear, we firmly believe that Congress will respond to the public cry for changes in the system. For most of us, the starting point for any discussion on health care reform remains needs to be the President's Health Security Act. So, Madame Chair, we commend you for holding this hearing.

We are pleased that this plan includes comprehensive generally affordable, and universal coverage for many primary and preventive reproductive health services.

For most American women, this is a major step forward in terms of coverage and may well represent the best we will ultimately achieve. However, even this plan, which I must emphasize again is a major move toward universal access to reproductive health services, still does not go far enough in assuring that voluntary family planning services will be available to all individuals to allow them to make informed decisions about when or whether to have children.

Because the plan still includes some barriers to service, and because the impact of the proposed changes on the existing Title X system of clinics is unclear, we are recommending that the plan be strengthened by making the following changes and clarifications:

First and foremost, the definition of covered family planning services needs to be changed. As it stands, it is neither as explicit nor as broad as we would like. The plan as currently written includes coverage for "family planning services," prescription drugs, which we understand includes oral contraceptives and Depo-Provera, contraceptive devices, and "services to pregnant women". Although this language covers many of the most critical family planning services—and thankfully includes coverage for the most expensive contraceptives, Norplant and Depo-Provera, this definition is still inadequate. We are asking that any health reform plan define family planning as the comprehensive list of services provided by Title X. In addition, we are recommending that the definition of covered family planning services be expanded to explicitly cover sterilization and oral contraceptives, although the Administration assures us that these last two items are in fact covered. Nevertheless, we in the family planning community know better than to take anything for granted.

This need for clarification of the definition of family planning is brought home by data from an ongoing study of private health insurance coverage of reproductive health services being conducted by the Alan Guttmacher Institute. The preliminary results of their survey offer a dramatic confirmation of the traditional bias against preventive care. While over 85 percent of all private insurance policies covered sterilization, and close to 70 percent cover abortion (although of this number, one quarter of the large group plans and one fifth of HMOs require a specific medical indication other than pregnancy itself), none of the five reversible methods of contraceptive is routinely covered by more than 40 percent of the private indemnity plans. Half of the large group plans typically do not cover any contraceptive methods at all, and only 15 percent cover all five methods. Oral contraceptives are covered by only one-third of the large group plans, 80 percent do not cover IUDs or diaphragms, and three-quarters do not cover Norplant. This data confirms the national inattention to and inadequacy of coverage for women's reproductive health needs.

Surprisingly, the Clinton plan does not remedy the mistakes made so often by private insurers in failing to classify family planning services and devices, as well as "services for pregnant women" as clinical preventive services. As a result, cost sharing requirements are imposed for family planning services—although in a different section, prenatal services are specifically excluded from copays and deductibles. The plan as currently drafted requires individuals not eligible for AFDC or SSI to pay either a $10 per visit copayment if they are enrolled in a lower cost sharing plan, or a 20 percent copayment if they are enrolled in a higher cost sharing plan. In addition, individuals enrolled in a low cost sharing plan will be required to pay a $5 per prescription fee. While $15 may not seem like a lot, you and I know it may put some women in the untenable position of choosing between food and birth control—a choice no woman should ever have to make. Individuals enrolled in higher cost sharing plans may have to pay hundreds of dollars up front to obtain a device such as Norplant. Even for women who are relatively affluent, these up front costs could effectively deny them access to their first choice of contraceptive method.

Thus, our goal of universal access to family planning services for all women could be furthered by reclassifying family planning as a "clinical preventive service"—the most sensible and accurate characterization of these services.

The Clinton plan also covers certain "clinical preventive services", including pap smears, mammograms, pelvic exams and screening for certain STDs for women. The plan establishes a periodicity schedule for these services and waives all copayments and deductibles for preventive services obtained at specified intervals. Many practitioners have already voiced their concern that the periodicity schedule established for pelvics, pap smears and mammograms is inadequate for many women, but we are pleased that diagnostic tests and exams are covered without copays and deductibles at any time. And it points out how important it is to ensure that contraceptive methods are specifically enumerated in whatever health plan is ultimately enacted.

In addition, the language regarding STDs is not sufficiently inclusive. The plan covers screening for what are referred to as "fertility-related infectious illnesses," which for purposes of the plan seems to include only chlamydia and gonorrhea. The

plan covers annual screening for these two STDs for females up to age 50 who have reached childbearing age and are at risk for fertility related infectious illnesses. The term "fertility related infectious illnesses" should be replaced with the more accurate term "sexually transmitted diseases". In addition, the limitation of screening to women "at risk" is far too subjective and judgmental and the absence of screening for males of any age for any STD also appears to be a significant oversight. Therefore, while the provision as drafted represents an improvement for many women because annual screening for chlamydia and gonorrhea for women under 50 is covered, it falls short in addressing screening for men or for other STDs such as syphilis and HIV. We are asking that screening for men for syphilis and voluntary screening for HIV be available to anyone. We recognize and support that the plan does allow for targeted screening for certain STDs in high risk areas.

Meaningful access to family planning services can also be furthered by building upon and utilizing the existing public health infrastructure. The Clinton plan goes some way toward maintaining the short term viability of Title X clinics but could potentially leave the clinics high and dry down the road. For the first five years of the phase-in of the plan, Title X clinics are one of the entities designated as "essential community providers." This designation will allow women to continue to use Title X clinics as their service site regardless of which health plan they select. However, the contracting safeguards to protect essential community providers against additional risks from adverse selection are insufficient. In addition, the essential community provider designation is not sufficiently expansive to encompass those clinics which may not receive Title X funds, but do receive public funds either from the state, from Title XX, or from Title V, and provide reproductive health services to low income women. We are also concerned that the initial five year period for designation as an essential community provider may be insufficient for clinics to become fully integrated into the reformed health care system.

Another provision of the bill which, on its face, seems reasonable is the "conscience clause." The conscience clause permits health professionals or health facilities to choose not to provide an item or service in the comprehensive benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction. This language, however, could prove to be a barrier to service and is even broader than the current language governing providers in Title X clinics. Although plans are still required to pay for all items and services in the comprehensive benefits package, including abortion and family planning services, we are concerned that the full range of options with regard to family planning, abortion, and sterilization may not be presented by certain health providers. We are also concerned that their opposition or reticence toward family planning services may discourage enrollees from seeking these covered services. As a practical matter, the distance and time needed to use other facilities could also limit access to covered services. We also remain concerned about the desire and ability of certain plans and providers with religious affiliations to impartially refer clients for services to which they may be morally opposed, such as abortion but also many methods of contraception and services for sexually active adolescents.

NFPRHA is concerned that the bill does not provide sufficient protection of confidentiality. There is no acknowledgement that family planning and abortion services are "sensitive" and require special protection. The privacy language in the Clinton bill speaks primarily to confidentiality of medical records and information. Although the plan generally guarantees privacy of information and prohibits unauthorized disclosure of any individually identified health information, it does not explicitly preclude notifying parents that a minor son or daughter has received a reproductive health service. We are especially concerned about services for adolescents whose parents may not know that they are sexually active, spouses who are seeking confidential services, bisexuals and IV drug users, and victims of sexual abuse and incest. Copayments and deductibles may also compromise confidentiality if clinics send bills for reproductive health services to parents or spouses.

NFPRHA also believes it is essential to assure continued and increased funding for Title X as a categorical program. How Title X fits into the ongoing health care reform debate is not always clear. What we do know is that family planning has been grossly underfunded since cuts were first made in 1981. Between 1981; 1991, funding for the Title X program in real dollars declined by over two thirds. Unfortunately, the Health Security Act does not ensure that categorical Title X funds will be available over the long term to continue providing cost-effective, efficient, essential services to low income Americans. While the bill includes funding for "Public Health Initiatives," and authorizes an appropriation of $1.1 billion in 1995, rising to almost $3 billion in 1996, the source of these funds is unclear and the dollar figure that will be available for the initiative will be subject to the vagaries of the an-

nual appropriations process. Congress must ensure that these funds not come from reductions in existing public health programs.

Finally, we recommend that the Health Security Act be amended to explicitly ensure that the Title X program continues as a categorical grant program.

Regardless of what bill emerges as the vehicle for health care reform, we in family planning community urge you and others in Congress to insist that:

There must be no copayments or deductibles for family planning service,

Coverage be universal, comprehensive, accessible, and affordable,

Any plan must mandate coverage for contraceptive services and supplies, abortion services, sterilization, routine pelvic exams, and screening for breast and cervical cancer, HIV infection, and sexually transmitted diseases,

Confidentiality must be guaranteed for reproductive health services,

Title X categorical funding for family planning should continue to fill gaps in underserved areas,

Individuals must have access to family planning services without gatekeeper approval, and

Individuals should retain the right to seek services of Title X clinics regardless of their choice of plan.

Thank you, Madame Chair for holding this important hearing. I look forward to working with you and your staff and Congress moves forward on health care reform.

Prepared Statement of Kate Michelman

Health care reform offers an unprecedented opportunity to end the shameful neglect toward women that has long characterized this nation's health care system. True reform must ensure adequate coverage for women's health needs. The National Abortion and Reproductive Rights Action League (NARAL) is committed to reform that offers affordable and universal coverage, a comprehensive benefits package and coverage for the full range of reproductive health services, including abortion.

Our nation's failure to protect and promote reproductive health is taking a terrible toll on women, children, families and our entire society. Each year, there are three million unintended pregnancies and one and a half million abortions in the United States.[1] Pregnancy rates among America's youth are at an epidemic high, with approximately one million teen pregnancies each year.[2] Sexually transmitted diseases are rampant, with 12 million sexually transmitted diseases occurring each year.[3] Almost 35,000 infants died in 1992, many from preventable causes.[4] These grim statistics reveal a health care system in crisis. More than nine million women of childbearing age (17 percent) and more than eight million children (12 percent) are completely uninsured.[5] Many more women, children and teens face additional and often insurmountable obstacles to preventive health care.

Through health care reform, Congress can provide all Americans with the chance to take personal responsibility for their health and that of their families. Because reproductive health care is an essential component of primary care for women, the full range of reproductive health services must be included in the comprehensive benefits package under national health care reform. Covered reproductive health services must include contraceptive care and counseling, preventive care including prevention of sexually transmitted diseases, prenatal and postnatal care, childbirth, and abortion services. Anti-choice politicians should not be permitted to jeopardize women's health by eliminating access to legitimate and essential reproductive health services.

ENSURING COVERAGE OF COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES

Ensuring adequate health coverage for all Americans—the primary goal of national health care reform—means that every person must have genuine access to the basic medical services that he or she may require. For most women, reproductive health care is the major form of health care that they receive during most years

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[1] Rachel Gold, Abortion and Women's Health (Washington, DC: Alan Guttmacher Institute, 1990): 11

[2] Centers for Disease Control and Prevention, "Teenage Pregnancy and Birth Rates—United States, 1990," Morbidity and Mortality Weekly Report, vol. 42, no. 38 (Oct. 1, 1993): 733

[3] Centers for Disease Control and Prevention, Division of STD/HIV Prevention, 1992 Annual Report, 29.

[4] Centers for Disease Control and Prevention, "Annual Summary of Births, Marriages, Divorces, and Deaths: United States, 1992," Monthly Vital Statistics Report, vol. 41, no. 13 (Sept. 28, 1993): 7, 28.

[5] U.S. Bureau of the Census, Poverty in the United States: 1992, series P60-185 (Washington, DC: U.S. Government Printing Office, 1993): 148.

of their lives. Thus, for American women, adequate health care coverage cannot exist without guaranteeing access to comprehensive reproductive health services.

Different women have differing reproductive health needs, and even the same woman has differing reproductive health needs at different stages of her life. A comprehensive national health care program must provide coverage for the whole woman throughout the many stages of life. For example, at different stages of her life, one woman might need routine gynecological exams, treatment of gynecological illnesses, various forms of contraception, and pregnancy-related treatment including pregnancy testing, prenatal care, and abortion. While all women will not need every reproductive health service, most women face many reproductive health decisions during their lifetimes. Women's ability to make and carry out reproductive choices is essential to their health and well-being and that of their families. National health care must not isolate one procedure for discriminatory treatment, but must assure coverage for the whole range of reproductive health care options.

Pregnancy is a health condition that requires medical attention based on a woman's individual needs, not political concerns. Care for pregnancy may involve medical services for pregnancy termination, or services to bring the pregnancy to term. The vast majority of women require pregnancy-related medical services at some point in their lives. More than eight out of ten women will have at least one child.[6] An estimated two-thirds of American women will have at least one unintended pregnancy in the course of their lives.[7] Determining coverage for pregnancy-related medical services based upon anti-choice politics rather than on the medical needs and condition of the individual woman would severely harm women's health and well-being.

Women, through their reproductive choices, assume personal responsibility for their own and their families futures. When a woman makes a reproductive health decision—to use a contraceptive, to begin or continue a pregnancy, to seek prenatal care, to have an abortion, to be treated for infertility—that is a life-shaping decision that only she can make.

MAINTAINING AND IMPROVING EXISTING HEALTH CARE COVERAGE

If national health care reform is to fulfill its promise, it must ensure coverage of the full range of reproductive health services. Private insurance plans typically recognize that abortion is integral to women's reproductive health and provide coverage for the procedure. The first large-scale study of private insurance coverage of reproductive health services, recently conducted by the Alan Guttmacher Institute, confirms that two thirds or more of all policies surveyed routinely cover abortion in their plans.[8] Excluding or limiting abortion services under national health care reform would strip coverage for abortion services from millions of women who are currently insured under private plans. As stated by an editorial in the New York Times: "To provide abortion services under a health insurance plan is not to give women a new benefit. Instead it's to continue the coverage most Americans already have under their private plans. To do otherwise is to discriminate against women, pure and simple."[9]

True reform must improve existing coverage by promoting preventive health care, including prenatal care and family planning services private health insurance has traditionally covered surgical services, but has failed to provide adequate coverage for women's health needs, including preventive care. For example, the AGI survey referenced above reveals that while sterilization services are routinely covered by at least 85 percent of all types of insurance policies, none of the five reversible means of contraception surveyed are covered by any more than 40 percent of typical policies.[10] At least five million women have health insurance that does not cover prenatal care and childbirth costs.[11] This approach to coverage continues to have a significant and detrimental impact on reproductive health.

A serious commitment to ensuring that Americans have access to the reproductive and preventive health services they need, including the full range of contraceptive

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[6] U.S. Bureau of the Census, "Fertility of American Women: June 1988," Current Population Reports, Series P-20, No. 436, 1988: 17.

[7] Jacqueline Darroch Forrest, 'Unintended Pregnancy Among American Women," Family Planning Perspectives, vol. 19, no. 2 (Mar./Apr. 1987): 77.

[8] Jeannie I. Rosoff, Testimony Presented to the Senate Committee on Labor and Human Resources, Mar. 9, 1994, p. 5 (on file with NARAL).

[9] Editorial, "Abortion and the Health Care Package," New York Times, June 12, 1993, A20.

[10] Rosoff, Testimony Presented to the Senate Committee on Labor and Human Resources, Mar. 9, 1994, pp. 5, 6.

[11] Alan Guttmacher Institute, Blessed Events and the Boston Line: Financing Maternity Care in the United States (New York: Alan Guttmacher Institute, 1987), 21, 43.

options and prenatal care, will improve the health of women and their families by helping to avoid unintended pregnancy, sexually transmitted diseases, and the significant physical, emotional and financial hardships that can arise from unhealthy or unwanted childbearing. In addition, genuine access to preventive and reproductive health care will help reduce the need for abortion.

THE HARMFUL EFFECTS OF DISCRIMINATION

National health care reform will significantly change the health care delivery system in this country and access to medical services not covered in the benefits package will be limited. Excluding abortion from the plan would be especially devastating to low income and rural women given the host of other anti-choice strategies being pursued to make abortion unavailable. Only women who could afford to purchase services outside the benefits package, and who could find a physician trained and willing to perform the procedure despite its exclusion from coverage, would have access to abortion. Singling out abortion for discriminatory treatment would perpetuate and exacerbate our two tiered health care system in which a woman's right to choose is dependent upon her ability to pay. No medical rationale supports the exclusion of abortion from national health care reform. Excluding coverage would increase the health risks for women who terminate their pregnancies by imposing financial and other constraints that cause risky delays.

In many areas—particularly rural areas—there is already a shortage of health care providers. Millions of women live in areas that are medically underserved.[12] For example, in 26 percent of counties, there is no identified source of clinical or hospital prenatal care.[13] The situation is particularly grave for abortion services. Nationwide, 83 percent of counties have no abortion provider.[14] Over 50 percent of metropolitan areas and 93 percent of nonmetropolitan areas do not have an abortion provider; North Dakota and South Dakota have only one abortion provider each.[15] Anti-choice extremists across the country are using violence, threats and intimidation to pressure physicians to abandon their abortion practices. The exclusion of coverage for abortion services from a standard national benefits package will exacerbate this severe shortage of physicians willing and qualified to perform abortions.

The American Medical Association concluded in a recent study that "a reduction in the number and geographic availability of abortion providers, and a reduction in the number of physicians who are trained and willing to perform first- and second-trimester abortions have the potential to threaten the safety of induced abortion."[16] Just such a dangerous reduction in the availability of providers can be expected if the national health care package isolates and excludes abortion from the basic benefits package.

Some women who could not overcome these substantial obstacles would be compelled to resort to unsafe abortions by unqualified providers or forced childbearing, and others would suffer delays resulting in more risky procedures. Even women of means may be forced to delay their abortions while looking for a provider. Although a first or second trimester abortion is substantially safer than childbirth, after eight weeks the risks of complications from abortion significantly increase for each week of delay.[17] The American Medical Association recently concluded that "as access to safer, earlier legal abortion becomes increasingly restricted, there is likely to be a small but measurable increase in mortality and morbidity among women in the United States."[18]

CONCLUSION

Americans are looking to Congress to act responsibly to ensure the health and well-being of women and families. I urge you not to succumb to anti-choice political pressures, and not to forget that each woman will face a range of reproductive health decisions during the course of her life. I urge you to enact a plan that fosters

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[12] U.S. Department of Health and Human Services, Office of Shortage Area Designation, Selected Statistics on Health Professional Shortage Areas as of September 30, 1993 (Washington, DC: U.S. Government Printing Office, 1993), 2.

[13] Susheela Singh, Jacqueline Darroch Forrest and Aida Torres, Prenatal Care in the United States: A State and County Inventory, vol. 1 (New York: Alan Guttmacher Institute, 1989), 60.

[14] Stanley K. Henshaw and Jennifer Van Vort, "Abortion Services in the United States, 1987 and 1988," Family Planning Perspectives, vol. 22, no. 3 (May/June 1990): 106.

[15] Ibid., 106.

[16] American Medical Association, "Induced Pregnancy Termination Before and After Roe v. Wade, Trends in the Mortality and Morbidity of Women," J.A.M.A., vol. 268, no. 22 (Dec. 1992): 3237.

[17] Gold, Abortion and Women $ Health, 29.

[18] American Medical Association, "Induced Termination of Pregnancy," 3238.

healthier planned pregnancies, decreases the number of unintended pregnancies, and makes abortion less necessary—not more dangerous or more difficult. Only by doing so will you truly protect women's health.

A national health care reform program that based coverage on political preferences rather than on the medical needs and condition of the individual pregnant woman would significantly limit women's ability to protect their health and well-being. Excluding abortion services would have the tragic effect of transforming much-needed health care reform into a dangerous and discriminatory denial of women's basic health care needs. Discriminatory legislation would constitute a missed opportunity to improve the health of America's women, children and families. For women, it would represent a giant step backwards.

At NARAL, we believe that health care reform is our nation's chance to change course, to encourage personal responsibility, to respect a woman's right to choose, and to make abortion less necessary through prevention, contraception and family planning. A health care plan that encourages meaningful decision-making by assuring access to reproductive health services will result in fewer unintended pregnancies, fewer abortions, and more healthy women and healthy babies. We want the new health care plan to ensure women the ability to make meaningful choices—not limit the choices they can make.

Statement of the American Heart Association

The American Heart Association submits the following testimony in response to S. 1757, the Health Security Act of 1993, in light of the treatment needs of women with cardiovascular diseases. The AHA is this nation's largest voluntary health organization dedicated to the reduction of disability and death from cardiovascular diseases, including heart attack and stroke. Annually, AHA's 56 affiliates nationwide coordinate the activities of about 3.7 million volunteers in carrying out this mission. Coronary heart diseases and stroke remain the single largest cause of death in the United States, and the number 1 and 3 killers of women, respectively.

Despite progress, cardiovascular diseases remain the No. 1 killer of women in the United States. Almost 46 percent of all female deaths in the United States are from cardiovascular diseases. More than one in five Americans have some form of cardiovascular disease. In America, all cardiovascular diseases combined claim more than 479,000 women's lives each year—more than double that of all forms of cancer combined (about 242,000.) Coronary heart disease alone kills more than five times as many women as breast cancer.

Until recently, cardiovascular diseases in women have not been recognized as a serious health problem, particularly by women themselves. Of the over 478,000 deaths from heart attack each year, 48.4 percent occur in women. Women, however, develop heart disease later in life than men. Since 1984 cardiovascular disease deaths of women have exceeded those of men.

At any age, heart attack in women is a more deadly disease than it is in men, but older women are twice as likely as men to die during the first few weeks following a heart attack. Thirty-nine percent of women who have heart attacks die within a year, compared with 31 percent of men. In the four years after an initial heart attack, a second heart attack occurs in 20 percent of women, compared to 16 percent of men.

In light of the deadly and disabling impact of cardiovascular disease on women, the AHA has focused its efforts on working with Congress and the Administration to ensure that health care reform includes the necessary elements for research, prevention and effective treatment of cardiovascular diseases. The American Heart Association appreciates the Clinton Administration's commitment to health care reform as embodied in the Health Security Act. No previous administration has demonstrated more commitment to the health care reform needs of this country.

The position of the American Heart Association on health care reform has been guided by our five principles on Access to Health Care, which the Association feels are critical to any health care reform package. The AHA principles are:

1. All residents of the U.S. should have access to quality medical care.
2. Universal coverage for basic medical care should he available.
3. Coverage for preventive care must be part of any access proposal.
4. Funds must be allocated for biomedical research, research training and clinical training.
5. The AHA should participate in the development of guidelines for appropriate patient care and should support research into methods to measure quality, outcomes and cost-effectiveness.

The American Heart Association reserves endorsement of any one particular health care reform proposal. However, the Association recognizes that many of its concerns are addressed in the Health Security Act of 1993.

In particular, the American Heart Association commends the Clinton Administration for emphasizing access to care in the Health Security Act, especially that, regardless of preexisting conditions, all U.S. residents must have access to quality medical care, including appropriate medications and prevention programs. In addition, the AHA applauds the Clinton Administration's commitment to universal coverage of basic medical care, including cardiovascular care.

The AHA is pleased to find the strong emphasis in the Health Security Act on effective utilization of resources, and we appreciate the support for the development of practice guidelines by professional groups with appropriate expertise. We are also pleased to see that Title V of the Act, Quality and Consumer Protection, would focus government resources on developing knowledge of treatment outcomes generated by health services research to determine not only clinical effectiveness, but also cost effectiveness.

The AHA is also pleased to see that the Health Security Act contains specific provisions to support health services research.

PEVENTIVE BENEFITS

The data on the incidence of death and disability resulting from cardiovascular disease indicates the value and cost-effectiveness of preventive efforts. Cardiovascular diseases are the leading cause of death in women in the United States and cardiovascular disease deaths are 63 percent higher for females than all female cancer, accident, and diabetes deaths combined. Each year more than 235,000 women die of a heart attack, and breast cancer claims the lives of about 43,300 females.

From 1979 to 1991, in white women, there was a 26 percent decline in age-adjusted death rates from diseases of the heart and a 36 percent decline in death rates from stroke, and among black women, a 17 percent and 33 percent decline, respectively. Despite these substantial declines in death rates, heart attack and stroke still rank first and third, respectively, as the causes of death in all women, with substantially higher rates among black women. With each decade of life, the rate of deaths from heart disease increases from 3- to 4-fold per decade, and by the age of 75 years the death rate in white women is over 1,800 per 100,000, and in black women over 2,200 per 100,000.

Since 1984, cardiovascular disease caused a greater proportion of deaths in women than men, that is, 51.8 percent in women and 48.2 percent in men. Death rates from cardiovascular disease, however, are only the tip of the iceberg; one in seven women between 45-64 years of age has some form of heart disease or stroke. After age 65 the ratio increases to 1 in 3 women. The number of women with cardiovascular disease continues to grow each year. Physicians should be aware that the perceived risk and fear of cancer seems much greater in women than their perceived risk of heart disease or stroke. Before women can take action regarding their cardiovascular risk, they must understand their risk of death or disability resulting from these diseases.

Another indication of the impact a disease has on society is the costs incurred. The costs in 1994 of cardiovascular disease is estimated to be $128 billion, including medical costs and the lost productivity resulting from disability. It is estimated that women consume over half, about 58 percent ($74.2 billion), of the yearly health care costs related to cardiovascular diseases, although they have about one-half the death rate of cardiovascular disease as men.

Other cardiovascular diseases are also prevalent in women. More than 86,000 women each year die of stroke. This comprises 61 percent of all deaths from stroke. Rheumatic fever is less prevalent, but even so, there is a higher death rate in women than in men (1.7-1.8 death per 100,000 for women, compared to 1.1-1.2 per 100,000 for men) resulting from rheumatic heart disease.

All told, heart and blood vessel diseases combined claim over 479,000 women's lives each year, more than all forms of cancer combined.

As a result of research, we are able to identify risk factors for cardiovascular disease, which can then lead to cost-effective prevention. Major atherosclerotic disease risk factors operate in women as well as in men. High blood pressure is a predictor of coronary artery disease in both women and men.

Smoking is another significant risk factor for heart attack in women. There are 23 million women smokers in the United States. They are 2 to 4 times more likely to suffer a heart attack than their non-smoking counterparts. In previous years we had seen a decline in the number of women smoking, but from 1990 to 1991, there was a 2.2 percent increase in smoking among women. Smoking is increasing in teen-

aged and young women. There are many reasons, not all related to medical issues. Nevertheless, this is an area that requires further study and intervention.

The AHA is pleased to see that, under the Health Security Act, preventive care is a significant part of the basic benefit package and that resources would be targeted to prevention of heart disease. The Clinton plan emphasizes preventive care, especially cholesterol screening.

Section 1114—Clinical Preventive Services

Section 1114 of the Health Security Act deals with the coverage of clinical preventive health services. While the intent of this section seems to be to ensure proper coverage of preventive health services under a standard benefits package, it is not clear from reading the section what is considered mandatory coverage. The Health Security Act's section on Clinical Preventive Services has the greatest potential for promoting health, preventing disease and reducing health care costs. Yet, when compared with the section on mental health and substance abuse services, for example, Section 1114 is vague.

The AHA strongly urges that this section specify far more clearly what preventive health services should be provided. For cardiovascular diseases and stroke, the nations number one and number three killers, this should mean, at a minimum, cholesterol screening, high blood pressure screening, nutritional counseling, smoking cessation counseling, as well as counseling on the importance of exercise.

Section 1127—Health Education Classes

This section allows a health plan to cover, at its discretion, health education and training classes designed to reduce behavior risk factors and promote healthy lifestyles. Specifically mentioned and supported by the AHA are smoking cessation, nutritional counseling, stress management, and physical training. AHA believes that qualified health education and training programs should be both available and covered under the Health Security Act.

The language of Section 1127 should be expanded to ensure inclusion of other health educational activities, particularly those types of education and training programs having the greatest health impact on the population. In addition to those specified, high blood pressure education, education on the "warning signs" of heart attack and stroke, and cardiopulmonary resuscitation should be considered for coverage as part of any comprehensive health education effort.

Secondary Prevention

In both Sections 1114 and 1127, efforts and attention should also be given to secondary preventive health needs following myocardial infarction, surgery, and angioplasty. These would include such interventions as rehabilitative counseling and exercise programs, which can reduce mortality by as much as 25 percent. This kind of secondary prevention is both cost-effective and cost-saving.

AHA position: The AHA believes that both the clinical preventive services provision and the health education classes provision of the Health Security Act need to be developed more fully to ensure that coverage is being provided to a number of preventive health services that are well established and accepted. These would include, but not be limited to, the various proposals listed above.

The AHA has developed a basic preventive benefit package, which is attached, and supports inclusion of its recommended benefits in the health plan.

BIOMEDICAL RESEARCH

Since 1948 the AHA and the National Heart Lung and Blood Institute have been active partners in the battle against cardiovascular diseases, including heart attack and stroke. Throughout this 45 year partnership, the research, training, education, and community service programs of both the AHA and the NIH have had a significant impact. From 1981 to 1991 the age-adjusted death rate from heart attack fell 32.4 percent and that from stroke fell 30.5 percent. This trend is largely attributable to advances in medical treatment, healthier lifestyles, and control of risk factors such as elevated blood cholesterol, high blood pressure, and smoking.

There is still a long way to go. In the United States someone dies from cardiovascular diseases every 34 seconds. More than one in five Americans suffer from some form of these diseases.

In 1990 total cardiovascular disease accounted for 4.740 million years of potential life lost before age 75, greater than for cancer and accidents. In the years to come there will be even more cardiovascular disability. This is because many people who have had effective treatment, for coronary artery disease and prevention of arteriosclerosis at age 40 to 60, will develop cardiovascular diseases later in life.

The estimated cost of cardiovascular diseases in 1994 will be $128.0 billion in medical expenses and lost productivity. Costs for patients with cardiovascular diseases grow because currently we are treating disease rather than preventing it.

Our ability to control cardiovascular diseases depends on the level of quality of overall support of basic and clinical research and prevention efforts. Throughout its history, the AHA has emphasized prevention, investing heavily in research. Basic research is the starting point of all medical advances. Biomedical research remains the number one priority of the AHA. Since 1949, the AHA has invested almost $1.2 billion in research and has developed education and community programs to promote health and to prevent and reduce the risk of heart attack and stroke. In 1992-1993 the IA, including its 56 affiliates nationwide, contributed almost $93 million to research. The size of this financial commitment makes the AHA second only to the federally-sponsored National Heart, Lung and Blood Institute as a principle supporter of cardiovascular research. AHA funded research has yielded many important discoveries, including CPR, life-extending drugs, bypass surgery, pacemakers and other surgical techniques to repair defects.

Research and prevention programs must be key components of health care reform because they save women's lives and money. Support for basic biomedical research funding is critical for innovative approaches to the diagnosis, treatment and prevention against cardiovascular diseases in women, including heart attack and stroke.

The AHA believes that funding for biomedical research, research training, and training of cardiovascular specialists must be included in health care reform. This includes the following: support for basic and clinical research at a level that allows reasonable growth; support for research training at a level that eliminates current downward trends in research manpower; and resources adequate to supply needed equipment and other types of scientific research infrastructure.

The AHA supports the position that basic biomedical research drives all other health research and that the allocation of funds for biomedical research is pivotal to any health care reform plan. In light of the data on the prevalence of cardiovascular disease in women, a substantial increase in support for biomedical research is critical for further advances in the diagnosis, treatment and prevention of cardiovascular disease in women.

In spite of the fact that there is no dedicated funding for biomedical research in the Clinton Plan, the AHA is pleased that Administration officials have indicated to AHA on a number of occasions that biomedical research funding is regarded as a critical component to national health care reform. The President's FY 1995 budget has only recommended a modest 4.7 percent increase in research funding for the National Institutes of Health.

AHA position: AHA has supported and has asked for the Administration's support for the Harkin/Hatfield National Fund for Health Research that would allow as much as a 50 percent increase in research funds to biomedical research efforts at the National Institutes of Health. Such a trust fund would serve as an additional source of funds, not a substitute for funds allocated through the appropriations process. A similar amendment is expected to be offered in the House, and we encourage your support for it.

ACADEMIC HEALTH CENTERS

We believe that the Clinton Plan, as currently drafted, would drastically reduce the ability of academic heath centers to function as the educational center for tomorrow's health care practitioner and the creation and expansion of medical knowledge on cardiovascular disease in women.

AHA position: Academic Health Centers are threatened by health care reform. Efforts should be made to ensure that the tremendous benefit that these institutions provide is not lost because of a basic lack of understanding of the crucial role that the centers play in our health system. We are concerned that Academic Health Centers are in danger, and if we lose their strength, this will have a major effect on the type of medicine we are able to practice in the 21st century.

Practice Guidelines

The AHA agrees with the Clinton administration and health policy experts that there are limits to the resources that the United States can provide for health care, and that government should not be expected to provide medical care without considering the appropriateness, efficacy, or cost-effectiveness of such care. Based on extensive research on cardiovascular diseases and stroke, including women and heart diseases, the AHA has a long and successful experience developing practice guidelines on treatments for cardiovascular diseases and stroke, and has done so in a cost-effective manner. For example, recently AHA, in conjunction with the American College of Cardiology, developed practice guidelines on congestive heart failure at

a very low cost, and, perhaps at less cost than what a federally-sponsored program can do.

AHA position: To ensure quality and cost-effectiveness of care provided, as well as an efficient process that eliminates government waste, AHA is asking the Administration to make sure that practice guidelines are developed by voluntary health organizations and professional groups with appropriate expertise.

SPECIALTY PHYSICIANS AS PRIMARY PHYSICIANS

Women being treated for cardiovascular disease often receive superior care at a cost savings when their primary care physician is a cardiologist or cardiovascular disease specialist. Because they are trained in diagnosis of heart diseases, specialists can provide effective appropriate care in a timely manner, thus avoiding delayed diagnosis and the higher cost of treatment as a result of delay.

AHA position: AHA supports provisions that affirm that nothing in the President's plan will prevent a person from using a specialty physician as their primary care physician when such a relationship is warranted.

The Senate Subcommittee on Aging's support for inclusion of these principles in health care reform is critical for continued progress in the battle against cardiovascular diseases in women, including heart attack and stroke.

Finally, AHA seeks your active support for a $2.00 excise tax on tobacco products to help finance health care reform. For too long the tobacco industry has made profits at the expense of health. A $2.00 excise tax is good fiscal policy, as well as good health policy.

STATEMENT OF LEONARD L. ROSS

Madam Chairwoman and members of the Subcommittee, I am Dr. Leonard Ross, President and CEO of the Medical College of Pennsylvania, the first and longest surviving medical school devoted to the education of female physicians. I appreciate the opportunity to testify before you today. I would like to take this opportunity to tell the Subcommittee about the Medical College of Pennsylvania's concerns with the inequities that currently exist in research and treatment in health care for women and the education of female physicians and the efforts the College has undertaken to address these issues.

The Medical College of Pennsylvania was founded in 1850 as the Female Medical College of Pennsylvania. In 1969, the institution became coeducational and in 1970 changed its name to the Medical College of Pennsylvania. Yet, despite changes in the institution's name and student body, the Medical College of Pennsylvania remains deeply committed to its roots as a pioneer in educating women in the medical profession and fostering critically needed education in those areas effecting women's health. This historic commitment continues to be reflected in the high percentages of women admitted to the school of medicine, and in the proportion of women holding senior level academic and administrative ranks, including professors, department chairs and deans. Today, the College has twelve residency programs featuring numerous programs and studies, either underway or in development, which significantly affect women's health care research and treatment.

The Medical College of Pennsylvania applauds the numerous legislative initiatives that have been introduced to enhance the focus and services of women's health care. However, without minimizing their importance we believe these are only just beginning steps toward creating a system that is truly fair and effective for women. Today, I would like to share with you those inequities we have identified in the current health care system which we believe can be reduced or eliminated as the health care delivery system experiences major reform.

A HISTORY OF INEQUITY IN WOMEN'S HEALTH

For centuries, as midwives, mothers, nurses and doctors, women have been the primary caregivers in their communities. Yet, despite the crucial role of women as health care providers, the history of women's health care can be characterized as one of great oversight and neglect. Women have been treated as second class citizens when it comes to receiving health care; their health needs and requirements have never received the quality research and treatment that has been routinely provided to men. It wasn't long ago that diagnostic techniques, treatments, research and education on the most common diseases had focused on men, while "women's" health research was largely understood to be investigations of the female reproductive system. This neglect is ironic because it is women who make three-fourths of the health care decisions in American households and spend almost two of every three health care dollars.

Women have been excluded from most clinical trials of treatment for cancer, heart disease and stroke, which are the leading causes of death in both men and women. Some of the reasons: concern that women's reproductive and menstrual cycles might alter test results by affecting the way drugs metabolized; fear that an experimental drug might harm the fetus of pregnant women enrolled in a trial; and possibly the most important, the assumption that diseases and the drugs for treating them affect both men and women the same.

In general, little credibility was given to the notion that women suffer from symptoms and illnesses different from those of men. For centuries medical students were being taught from a curriculum where the principles of health care were based solely on male physiology. That ignorance, too, often resulted in improper and costly treatments for women, such as unnecessary hysterectomies and mastectomies.

Another barrier to improving women's health has been their significant underrepresentation in the senior ranks of academic medicine. Today, only 10 percent of full professors are women; 4 percent of the department chairs in academic medicine are held by women; and there are only 3 women deans of the 126 medical schools in this country. As long as this void of women leaders is tolerated, women's health issues will continue to face challenges in gaining appropriate recognition within the medical community.

Despite all the negative aspects surrounding women's health, women's health issues are beginning to be recognized. One significant achievement was the establishment of the Women's Health Initiative, at the National Institute of Health. This is an ambitious $625 million study of more than 100,000 women. A key goal is to provide information on the determinants, markers and treatments of a host of illnesses, including breast, colon and rectal cancer, heart disease, and osteoporosis. The Women's Health Initiative is a pivotal first step towards correcting the vast inequalities which have existed in women's health research. However, it is only a beginning.

MEETING THE CHALLENGE

When the Medical College of Pennsylvania was founded in 1850 as the country's first medical school for women, traditional health care for women was largely left to midwives and the college's first women graduates were taunted, barred from hospitals or, at best, ignored by their male colleagues. Over the years, the Medical College of Pennsylvania and its graduates have broken down countless barriers to women as physicians, and have made many valuable contributions to women's health care.

However, to improve health care for women, changes must be made at every level. New curricula are needed for teaching the physicians, nurses and allied health professionals of today and tomorrow. New models of providing clinical care are needed to give women comprehensive, easily accessible care that takes into consideration their socioeconomic as well as medical needs. New information from medical research must be effectively translated into educational programs and improved health care. Finally, new programs which identify and foster women leaders need to be developed.

In recognition of this, the Medical College of Pennsylvania is establishing the Institute for Women's Health. The Institute will bring together all aspects of women's health into one comprehensive, interdisciplinary program, with the over-arching goal of providing a higher quality of health care to all women.

THE INSTITUTE FOR WOMEN'S HEALTH

The Institute for Women's Health will incorporate: The integration of women's health issues into medical, nursing and allied health education; Model clinical programs that address all aspects of women's health, including access to care; A center to develop and support women leaders in the health professions; The country's largest archives devoted to women in medicine; Research in women's health; and Methods to effectively translate research into improved patient care and medical education.

The Institute will draw on the diverse resources of one of the nation's largest academic-based health care systems—Allegheny Health, Education and Research Foundation (AHERF), of which the Medical College of Pennsylvania is a member. AHERF offers medical education, nursing education, allied health education, and advanced degrees in basis health sciences; research programs in basic and clinical sciences; and the entire spectrum of health care, from primary care practices and community hospitals to a pediatric specialty hospital and three tertiary care academic medical centers. The AHERF system has approximately 3,000 beds, over 2,800 students, 3,200 faculty members and almost 18,000 employees.

Clinical Care

As a clinical component of the Institute, the Medical College of Pennsylvania has committed its own resources to develop a model Center for Women's Health that provides comprehensive, integrated care in one convenient location. While many other programs marketing themselves as women's health centers offer no more than ob/gyn services or mammograms, the College's program focuses on providing health care for the whole woman.

Now in its second year, the Center for Women's Health incorporates primary care in internal medicine, obstetrics and gynecology, as well as the services of a nutritionist, a psychologist and a nurse educator, who spends time teaching patients about their health. It also provides access to specialists in areas ranging from exercise to infertility to easing disorders to headaches. Most patients can receive all the care they need at the Center, coordinated by their physicians and other health professionals. Special interdisciplinary programs are available in areas such as premenstrual syndrome, menopause, incontinence, osteoporosis, repetitive pregnancy loss and weight loss. Adjacent is the College's Breast Center, providing care and support to women with breast cancer, women at high risk of developing breast cancer, and women with breast implants. Mammograms are available on site.

The Center for Women's Health emphasizes good health and disease prevention through nutrition, exercise and routine medical care. By incorporating preventive measures such as cancer screenings and evaluations of such risks as cardiovascular disease and osteoporosis, the Center helps women lead healthy lives. Health education is a crucial part of its mission; the Center maintains a women's health library and produces an educational newsletter for its patients and women in the surrounding area.

The Institute for Women's Health plans to expand upon this model for providing women's health care by establishing three additional women's health centers in diverse locations throughout the Philadelphia area. By targeting different populations of women in inner-city and suburban areas, using variations of the program and studying the successes of each, the Institute will develop models that can be used across the country to provide improved health care for women. Tentative plans call for one of the centers to be located at one of the College's teaching hospitals—Medical College Hospitals, Elkins Park Campus (formerly Rolling Hill Hospital) in Montgomery County, Pennsylvania—while the other center sites are yet to be determined.

Medical Education

The Medical College of Pennsylvania is the first medical school in the country to have undertaken women's health education at the undergraduate, graduate and faculty levels. The Institute will expand upon work that has already begun, to develop and implement model women's health education programs that can be integrated into the teaching programs of medical, nursing and allied health schools, into medical residency programs and into continuing education programs for practicing health professionals.

Women's Health Research

Recognition has finally come nationwide that women's health issues must be addressed in medical research, from the most basic studies in immunology and cellular biology, to clinical trials of new treatments, to studies of social problems that affect women.

The Medical College of Pennsylvania has many ongoing research programs focused on women's health care, and will continue to seek out funding for such projects. Among the current programs are studies of the influence of cocaine addiction in pregnant women and their fetuses; the effects of rape and other forms of abuse; indicators of breast cancer; immunologic function in aging women; health risk factor modification in high school students; cardiovascular disease in minority women; headache in women; and clinical trials in gynecologic oncology. Other studies are looking at how well elderly women recover from hip fractures, how strength training helps them retain their independence, and other determinants of independence for elderly women.

Archives and Special Collections on Women in Medicine

The Institute for Women's Health will have access to a depth of knowledge of women in medicine greater than that at any other institution, thanks to the Medical College of Pennsylvania's existing Archives and Special Collections on Women in Medicine—the country's most comprehensive collection of its kind. The Archives will be a part of the Institute, where it will continue and strengthen its mission of col-

lecting and disseminating historical and current information about women in medicine worldwide.

In addition to the archives of the College, this collection contains the personal papers of women physicians from all over the world; organizational records of the American Women's Hospital Service (a group organized during World War I to provide medical care to other countries); the historical collection of the American Medical Women's Association; business records of some of the now-defunct 19th-century women's medical schools and women's hospitals; more than 5,000 reprints and 800 books on women in medicine; memorabilia; and a rich photographic collection of more than 12,000 images documenting the lives of women medical students and physicians the world over—from 1850 to the present.

As you can see, the Medical College of Pennsylvania remains committed to the implementation of a comprehensive women's health care program. The current national health care debate in which we engage today provides our nation's leaders with a critical and necessary opportunity to address the serious issues and challenges involved in this effort. It is essential that during this process Congress recognizes and includes funding not only for provision of adequate health care services for women, but also for basic research regarding diseases unique to women and diseases which may have features unique to women and for research on effective health care delivery systems for women. We at the Medical College of Pennsylvania hope you will not hesitate to call upon our experience in providing leadership in women's health care research and medical education, and will consider us as a resource in this critical debate.

Madam Chairwoman, thank you again for the opportunity to testify.

STATEMENT OF JUDITH L. LICHTMAN

The Women's Legal Defense Fund has worked for two decades to secure reproductive freedom, fight job discrimination, help Americans balance work and family responsibilities, give women access to quality health care, improve women's economic status, and reform the nation's child support system.

First, we want to thank Senator Mikulski for holding this hearing on women's health. Given the depth of your knowledge and expertise, and your invaluable leadership on women's health issues over the years, it is especially appropriate that you be the one to convene this hearing.

As you know, women's health care is at a critical and defining moment. we must not underestimate the far-reaching ramifications of policy decisions that will be made over the next several months. The President and this Congress are poised to dramatically reshape our nation's health care system. The outcome of this process will determine for decades to come what health care services women have (and do not have) access to.

For the first time, all women (and men) will be guaranteed access to a nationally set package of health care services, including essential preventive services. Decisions about what is in that package must be based on what is needed to protect our health and well-being. We must not let limited resources work to deny women their most basic health care needs. All women, particularly low income women and others who historically have had difficulty obtaining needed health care services, will be looking to this Congress and to the President to do the right thing.

We emphasize this point because there is a long history of women's health issues being given short shrift in this country. There has been a paucity of research into women's health needs and a disgraceful lack of progress in understanding, preventing and treating diseases that primarily affect women. The historical failure to include women in clinical research trials and to conduct research on conditions primarily affecting women has left major gaps in our knowledge about women's health needs. In the past few years, attention has finally begun to focus on the appalling lack of research into women's health needs, even capturing the attention of the media. But, nevertheless, we have a long way to go.

We raise this point also because women's health care services, and most especially their reproductive health care services, traditionally have been fragmented, isolated and marginalized in ways that negate the integral connection between women's reproductive health and their general health and well-being.

And finally, we make this point because decisions about women's health, especially reproductive health, are all too often determined by politics and what are perceived to be the prevailing winds of public opinion, rather than sound medical judgment and desired health outcomes.

For women to participate in this society on an equal footing with men, their health needs must be met. This means that this country must make a commitment to know more about women's health care needs and to ensure that women benefit

from advances in scientific research and technology, including the most effective ways to detect and treat conditions that affect women. We must commit to ensuring that women have access to the highest standard of services. We must meet the health care needs of all women, especially those who historically have been shut out of the system.

For health care reform to be effective and complete, it must embrace the following key principles:

1) It must provide universal coverage. We cannot provide care for only some of the people, some of the time. We must ensure that all have access to care, regardless of whether or where they work, with whom they live or how sick they are or may become.

2) It must ensure access to comprehensive benefits. We cannot include some of the health services that women need and exclude other essential services.

3) It must emphasize preventive services, services that can dramatically improve health, end unnecessary suffering and save money down the line.

4) It must ensure equal access to health care. This means lifting financial and other barriers that impede access to care, so that health care coverage is affordable and available, and eradicating our two-tiered health care system.

5) Health care must not be denied or delayed on the basis of health status or pre-existing conditions or one's employment or family status.

6) Reform must ensure that people receive quality care, not just for those with means, but for all.

7) Reform must provide the security of knowing that affordable health care will always be there when you need it, regardless of whether or where you work, whether you change jobs or lose your job, with whom you live or how sick you are or may become.

8) Reform must ensure that people have choices in deciding who provides their care.

9) Reform must ensure that women, people of color and other protected classes are not discriminated against and shut out of the system.

10) Reform must include a comprehensive research agenda for women, so that women are no longer treated like second class citizens.

11) Reform must ensure that health services are provided confidentially.

The Health Security Act (H.R. 3600/S. 1757) goes a long way toward meeting these critical objectives for reform. Passage of this legislation would be a tremendous step forward for women and their families.

Judged against the principles outlined above, the Administration's8 proposal generally fares well:

1) HSA's promise of universal coverage is undoubtedly the most critical aspect of this legislation.

2) HSA's promise that all women (and men) will receive the services spelled out in the comprehensive benefits package is another critically important aspect of this legislation.

3) HSA's focus on preventive health care is long overdue and will undoubtedly help to improve health status, eliminate human suffering and reduce costs.

4) HSA strives to create equal access to care. HSA creates a complex network of subsidies to assist in making health care affordable. It also strives to maintain and improve our public health infrastructure, so that community-based care will be available. HSA integrates Medicaid within the major delivery system, and thus goes a long way toward getting rid of our current two-tiered system—on the path to ensuring that all, regardless of income, will receive adequate, quality health care services.

5) HSA provides coverage regardless of health status or pre-existing conditions. Due to its employer mandate and the alliance structure, HSA goes a long way toward eliminating the inequities in our current employer-based system.

6) HSA aspires to ensure quality care, though questions remain about how well this goal has been accomplished.

7) HSA provides a measure of health security—a guarantee that health care will be there when you need it.

8) HSA provides enrollees with choice among plans and providers.

9) HSA contains provisions to ban discrimination in the new health care system, but these provisions need improvements.

10) HSA contains a research agenda, but the details remain to be fleshed out.

11) HSA contains many privacy provisions but does not ensure confidentiality of care.

Despite the good news, there are some important shortcomings in the HSA. In our evaluation of the HSA, the Women's Legal Defense Fund focused on issues that are of specific importance to women. These issues include (but are not limited to):

1) coverage of the full range of reproductive health services;
2) coverage of long term care;
3) coverage of mental illness and substance abuse services;
4) coverage of prescription drugs;
5) concerns of low income women (subsidies for low income people and the impact of mainstreaming Medicaid);
6) the impact of the HSA on women due to their family status;
7) the impact of the HSA on women due to their employment status;
8) civil rights protections for women and people of color;
9) health research priorities; and
10) confidentiality issues.

Below we discuss each of these areas and our major concerns about the HSA.

Reproductive Health Services

The HSA provides for coverage of a wide range of reproductive health services, including: prenatal care, delivery services and postpartum care; family planning services (including FDA-approved prescription drugs and devices); sterilization services; infertility services (except for in-vitro; fertilization, which is explicitly excluded); abortion services; annual screening for chlamydia and gonorrhea available free for women at risk; diagnosis and treatment for all sexually transmitted diseases; cancer screening tests such as Pap smears, clinical breast exams and mammograms (subject to specific age and frequency limits); diagnosis and treatment for cancers of the reproductive organs.

We applaud the Administration's inclusion of these critically important services in the comprehensive benefits package. Nonetheless, some improvements are needed in the reproductive health package.

Because these services are so basic and essential to women's health, it is critical that HSA include a guarantee that all these services will be-provided in each health plan's network of providers. The lower cost sharing plans and the mid-level combination cost sharing plans contemplate that enrollees may at times need to go outside the plan's network to obtain essential services when such services are not available in their plan. However, this would entail additional costs. Women should not be required to pay additional costs to obtain access to basic services; for low income women, such costs may be prohibitive and act as a barrier to obtaining needed care. Once again, we would find ourselves trapped in a two-tiered system of care.

HSA allows "a health professional or a health facility" to decline to provide any services if the provider objects to providing such services on the basis of a religious belief or moral conviction. (Section 1162) This so-called "conscience clause" will undoubtedly affect the provision of reproductive health services, from family planning services to sterilization services to abortion services. While we agree that a conscience clause for health care providers is appropriate, the conscience clause in the HSA is written in so broad a manner that it has the potential to deny huge numbers of women access to needed care. It is imperative that this language be refined to ensure that it applies only to individuals and private institutions that are religiously controlled, not to public institutions at all.

Another major shortcoming in the HSA's provision of reproductive health services is in screening for breast and cervical cancer. HSA contains age and frequency limits on clinical breast exams, Pap smears and mammograms that fall short of the recommendations of the American Cancer Society and the majority of medical and scientific organizations that have screening guidelines. The importance of early detection cannot be overstated: early detection and improved treatment for breast cancer have kept death rates stable despite increasing rates of incidence; the death rate for cervical cancer has declined more than 70 percent, due primarily to regular checkups and Pap smears.[1]

While it is extremely positive that preventive cancer screenings would be provided free of charge, it is nevertheless essential that they be provided with adequate frequency. If "prevention" is an integral and cost-effective tenet of this system, then we must provide enough of it to be effective. To do otherwise is like installing one smoke alarm in an eight-story building. Toward that end, existing American Cancer Society guidelines for cancer screening must be followed until such time as adequate research has been done that would justify any change in current recommendations.

Furthermore, for preventive services to be truly effective, it is essential that they be made available with as few barriers or disincentives as possible. This means providing them without co-payments or deductibles. HSA recognizes this and provides prenatal care and what it calls "clinical preventive services" free of charge. Nevertheless, HSA fails to cover a critical aspect of women's reproductive health care in

[1] American Cancer Society, Cancer Facts & Figures—1993, pp. 11-14.

this manner. It does not cover family planning services—the quintessential preventive service—in this manner.

Another shortcoming in HSA's coverage of family planning services is the failure to state explicitly that voluntary sterilization services and contraceptive drugs are covered family planning services.

Finally, although HSA provides for a very comprehensive range of reproductive health services to be covered, it explicitly excludes in vitro fertilization, which is an essential service required by a small minority of infertile couples. While in vitro fertilization and similar treatments account for less than five percent of infertility services, they are essential services for couples for whom no other treatment is available.[2] This omission should be corrected.

Long Term Care

Long term care is an aging issue; it is a family issue, and it is a women's issue. One third of people needing long term care are children, younger adults, or disabled persons[3] and the burden of their care falls generally on women. Not surprisingly, adult women are more likely than men to need long term care and to be the caregivers of such services. Approximately 75 percent of nursing home residents and 75 percent of people living in the communlty with limitations in activities of daily living are women.[4] Approximately 72 percent of unpaid caregivers for the elderly are women.[5] Indeed, the average woman can expect to spend 18 years caring for an elderly parent.[6] Whether recipients of such care or caregivers themselves, women need health care reform to address long term care services.

WSDF is glad to see that HSA makes a start toward providing critically-needed long term care services through a program of home and community based services. A range of services—from adult day care to respite care to rehabilitation services—would be available under this bill to eligible individuals. Eligibility would depend on degree of impairment and would include both mental impairment as well as need for assistance with activities of daily living.

Unfortunately, however, these services are not currently proposed as part of the comprehensive benefit package, but rather as a separate block grant program. This will limit the amount of money states have to provide these services and give states considerable discretion in deciding what services to provide and to whom. Receipt of services will thus depend on annual appropriations, the vagaries of politics and on state program design.

Nor is nursing home care covered under this new program, a shortcoming with significant ramifications for women, who constitute the bulk of nursing home residents. HSA does, however, make some improvements in Medicaid eligibility for nursing home care for those poor enough to qualify for Medicaid.

Mental Illness and Substance Abuse

HSA rightfully recognizes that services for mental illness and substance abuse must be provided. For women, these services are especially important. According to a recently published study, women are much more likely than men to suffer from depression or anxiety disorders.[7] Although women are much less likely to suffer from substance abuse than men, women, especially pregnant women, often have great difficulty finding alcohol and drug treatment programs.

The bill wisely covers services in a wide range of settings,including inpatient and residential treatment, intensive nonresidential treatment, and outpatient services. Although varied eligibility requirements apply to these services, all persons will have access to screening, assessment and crisis services. Family members can receive "collateral services" to help them cope with their loved one's mental illness or substance abuse, but only if the family member with mental illness or a substance abuse problem is in treatment.

While we applaud the Administration for including these services, we are nonetheless extremely concerned about the day/visit limits on coverage and about the

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[2] The American Fertility Society, Infertility: Questions and Answers (November 1993).

[3] Testimony of Stephen McConnell, Alzheimer's Association, Representing the Long Term Care Campaign, before the Committee on Ways and Means, Subcommittee on Health, November 2, 1993.

[4] American Association of Retired Persons (AARP), Toward A Just and Caring Society: The AARP Public Policy Agenda 1993, p. 37.

[5] AARP, Toward A Just and Caring Society: The AARP Public Policy Agenda 1993, p. 41.

[6] The Subcommittee on Human Services of the Select Committee on Aging of the U.S. House of Representatives, Exploding the Myths: Caregiving in America, Comm. Pub. No. 99-611, 100th Cong., 1st Sess. p. 9.

[7] Ronald C. Kessler, PhD., et al., "Lifetime and 12-Month Prevalence of DSM-III-R Psychiatric Disorders in the United States," The Archives of General Psychiatry, vol. 52 (January 1994), pp. 8-19.

high co-payments that would be required for this type of care. These barriers will prevent many people from getting effective treatment. We also believe that collateral services (discussed above) should be available even if the family member with the problem is not in treatment. We also are concerned that by lumping together mental illness and substance abuse services and placing day/visit limits on the amount of services one may obtain, people needing both mental health and substance abuse services will not get all the care they need.

Prescription Drugs

Coverage of prescription drugs is important to women's health. Women use prescription drugs more than men, and the elderly, especially elderly women, are the largest users of prescribed medications.[8] Elderly women constitute 11 percent of the population, yet 25 percent of all drug prescriptions are written for them.[9]

HSA provides coverage for prescription drugs in two ways: as one of the benefits in the comprehensive benefit package; and as a new Medicare benefit. While we applaud inclusion of these benefits, we are concerned that required co-payments may render this benefit of little use to many individuals. For those who are part of the alliance system, one of the cost-sharing plans has a $250 prescription drug deductible for each individual in the family before the plan will cover the costs of prescription drugs. For those on Medicare, the possibility exists that out-of-pocket costs for drugs could reach $1,000 per year. Since the average annual incom6 of women over the age of 65 is approximately $8,044,[10] these costs could prove prohibitive.

Primary Concerns of Low Income Women

Adequate health care is central to the vitality of low income families. Members of low income families are more likely to experience serious health problems such as heart disease and diabetes, and infectious diseases like tuberculosis.[11] Poverty is unfortunately a women's issue. About one third (34.9 percent) of families headed by women have incomes below the poverty line, compared to 15.6 percent of households headed by males and 6.2 percent of married-couple households.[12] Over half of all poor families (52.4 percent) are headed by women. A disproportionate number of these families are headed by women of color. How reform treats these low income families is a critical measure of success.

There are some positive ways in which low income families will fare under the HSA. First, we are glad to see that Medicaid beneficiaries will receive health care through the alliances like everyone else; this is an important step in ending our two-tiered health care system. Second, HSA provides subsidies for plans at or below the weighted average premium, and will thus allow low income people to choose from plans up to the average cost plan.

Despite these good points, there are problems with HSA's treatment of low income people, especially low income pregnant women.

1. Subsidies

HSA contains a complex array of provisions dealing with subsidies for low income individuals. Concerns about these provisions include:

a) Premiums are waived for AFDC/SSI recipients who will have varying levels of income depending on what state they live in. Income levels, not receipt of public assistance, should govern eligibility for subsidies.

b) The premium subsidies are not adequate, especially for some categories of part-time workers. (See discussion of employment-related issues.)

c) Premium subsidies only help with the purchase of up to the average priced plan. The lack of subsidies for higher priced plans will keep low income people in the cheaper plans. As a result, it is essential that there be adequate assurances of quality care in those plans.

d) Co-payments are reduced only for AFDC/SSI recipients, but even these reduced co-payments exceed current Medicaid co-payments. Low income families who do not receive AFDC/SSI would be required to make the same co-payments as more affluent people enrolled in the lower cost sharing plan.

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[8] Families USA, Prescription Costs: America's Other Drug Crisis (September 1992), p. 2.

[9] The Jacobs Institute of Women's Health, The Women's Health Data Book (Jacqueline A. Horton, Sc.D., ed., 1992), p. 82.

[10] Testimony of Joan A. Kuriansky, Chair, Campaign for Women's Health, before the House Ways and Means Committee, November 15, 1993, p. 2.

[11] Testimony of Diane Rowland, Sc.D., Senior Vice President,Henry J. Kaiser Family Foundation and Executive Director, Kaiser Commission on the Future of Medicaid, before the Committee on Energy and Commerce, Subcommittee on Health and the Environment,November 19, 1993, pp. 2-3.

[12] Bureau of the Census, Poverty in the United States: 1992, p. xv.

e) In addition to inadequate premium subsidies, lack of assistance with co-payments will effectively keep low income people in the lower cost sharing plans.

f) HSA requires lower cost sharing plans (generally closed panel HMOs) to offer enrollees the option of choosing providers outside the plan's network. An additional unspecified premium will be charged for this option, but it is not clear whether premium subsidies would be available to purchase this option. The out-of-network option also requires the payment of higher co-payments. If low income people do not get premium subsidies or adequate assistance with co-payments for out-of-network services, they will be locked into closed panel HMOs.

g) The maximum out-of-pocket limits for all services are absolute dollar amounts; they are not related to income level. This means that a much bigger chunk of a lower income person's family income can be required to go for health care.

h) Poverty level and family size definitions discriminate against families with more than two children. For other federal programs, poverty level is adjusted for family size, because larger families need more income to avoid poverty. However, for HSA purposes, all families are, in effect, deemed to have no more than two children. Thus, larger families—who may have higher incomes but still be poor under federal poverty guidelines—may not qualify for a subsidy.

2. Impact of Mainstreaming Medicaid on Pregnant Women

Great progress has been made over the past decade in delinking Medicaid from eligibility for welfare and in providing health care through the Medicaid program for low income pregnant and post-partum women. These improvements have resulted in Medicaid coverage of pregnant and post-partum women with family incomes up to 133 percent of poverty (and in 25 states up to 185 percent of poverty).[13] This coverage is provided at no cost to the woman. Under the HSA, however, because the Medicaid program would be eliminated for people who do not receive AFDC (welfare) or SSI, low income women now eligible for Medicaid who do not receive AFDC or SSI will be required to pay for their premiums, with the amount depending on their employment status and the level of their income. Co-payments for some pregnancy-related care also will be required, depending on the type of cost sharing plan.

In addition to medical services, states currently have the option to provide supplemental services such as transportation, nutritional counseling and home visiting to all Medicaid-eligible pregnant and post-partum women (not just to those who are on Medicaid because they receive AFDC or SSI).[14] Under HSA, supplemental services will continue only for those who receive Medicaid because they receive AFDC or SSI. This represents a loss of services for pregnant and postpartum women who are not AFDC/SSI recipients but are nonetheless currently eligible for Medicaid (including women pregnant with their first child). These services often make the difference in whether this vulnerable population has access to needed care.

Family Status Issues

Family status is a central concept in the HSA; premiums are allowed to vary only by family status (individual, couple, single-parent family and dual-parent family). As a result, how one's family is categorized will determine the premium each family (and employer) will pay. We have some concerns about how families are defined as well as how changes in family composition would affect responsibility for payment of premiums under the bill.[15]

As currently proposed, the couple class and the dual-parent family class require that the partners be married (as defined by state law), which will virtually preclude unmarried heterosexual, gay and lesbian couples from qualifying for these classes.Partners who are not married will be disadvantaged if the sum of the premiums for two individuals exceeds the premium for a couple (the Administration estimates that it will not), or if the sum of the premiums for an individual and a single parent

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[13] Under current law, states must cover pregnant women with incomes up to 133 percent of the poverty level, with the option to expand this coverage to those with incomes up to 185 percent of poverty. According to the National Governors' Association, 34 states have expanded eligibility above the mandated level of 133 percent; twenty-five of these 34 states cover pregnant women up to 185 percent of poverty. Two states, Minnesota and Vermont, have taken advantage of further flexibility to expand their income limits to 275 and 200 percent of poverty, respectively. National Governors' Association, State Coverage of Pregnant Women and Children—July 1993, Table 1.

[14] According to the NGA, 37 states currently provide home visiting, 36 states provide nutritional counseling, and 12 states provide transportation. National Governors' Association, State Coverage of Pregnant Women and Children—July 1993, Table 10.

[15] Our major concern is not whether changes in family composition will affect receipt of health care services—because continuation of services is guaranteed—but rather how changes in family composition will affect who pays what premium. HSA leaves these questions unanswered.

(or two single parents) exceeds the premium for a dual-parent family (the Administration estimates that it will).

Given the importance of family status to the premium structure, it is surprising that HSA contains no specifics about how changes in family composition will affect payment of premiums. Instead, HSA provides that such issues will be determined by the National Health Board.

Employment Status Issues

1. Women in the Workforce

Under our current health care "system", where health insurance status depends on whether one's employer chooses to provide insurance, women are disadvantaged. Women comprise most of the growing "contingent" workforce in the U.S., which at an estimated 3.9 million employees is the fastest growing segment of our labor force. Contingent workers include part-time,temporary, contract and casual employees. The Bureau of Labor Statistics reports that over two-thirds of all part-time workers are women; twenty-five percent of all working women work part time. More than three-fifths of all temporary workers are women.[16] Many of this country's seasonal agricultural workers are women.

Legions of contingent workers lose out on the benefits that are often taken for granted in full-time employment—benefits that include seniority-based compensation, pensions, and significantly, health insurance. Only 23 percent of temporary employees and 22 percent of part-time employees receive health insurance benefits through their employers.[17] Moreover, the Bureau of Labor Statistics reports that only five percent of part-time workers in firms with less the 100 employees have employer-provided health care coverage.[18]

In addition, even if they work full-time, women on average work for lower wages than men and are more likely to work in jobs that do not carry health insurance benefits. Women are disproportionately represented in jobs paying $20,000 per year or less: nearly 70 percent of all women workers earn less than $20,000 per year and 4? percent of all women workers earn less than $10,000 per year.[19] New data shows that 32 percent of U.S. workers earning less than $10,000 per year lack health insurance coverage of any kind. A full 88 percent of the uninsured are in families with an estimated adjusted gross income of less than $20,000 per year.[20]

Women are the majority of workers in the growing service providing industries and in smaller firms, which have the lowest rates of providing benefits. For example, women hold more than 52 percent of the nation's retail trade jobs and 62 percent of service industry jobs (working in industries such as hotels, personal services, educational and social services, and health services).[21] A typical service sector job is in a smaller-sized firm, pays little better than the minimum wage, and does not provide health insurance coverage. Thirty percent of employees working in firms with less than ten employees are uninsured.[22]

It is these low-wage workers—contingent workers, service industry workers and those in small firms—who can least afford to buy health insurance for themselves and their families without employer assistance.

2. HSA's Impact on Women in the Workforce

HSA would build on our current system in many respects by retaining the link between employment and insurance. A major improvement to our current system is HSA's requirement that employers—even small employers—contribute to the cost of their employees' health insurance. Coverage of small employers will benefit women and their families enormously. However, a major problem in the HSA is its failure to define "employee" to determine who is an independent contractor and who is an employee. Since employers are only required to contribute towards the premiums of

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[16] Economic Policy Institute, New Policies for the Part-Time and Contingent Workforce (Virginia L. duRivage, ed., 1992).

[17] Economic Policy Institute, New Policies for the Part-Time and Contingent Workforce (Virginia L. duRivage, ed., 1992).

[18] U.S. Department of Labor, Bureau of Labor Statistics, reported in Daily Labor Report, No. 18, p.B-7 (January 28, 1994).

[19] U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P60-184, Money Income of Households, Families, and Persons in the United States: 1992.

[20] Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1993 Current Population Survey (January 1994).

[21] U.S. Department of Labor, Bureau of Labor Statistics,Employment and Earnings (January 1991).

[22] Employee Benefits Research Institute, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1993 Current Population Survey (January 1994).

"employees" and not independent contractors, this classification makes a significant difference in who pays how much.

HSA's impact on women who work in small businesses is clear: they would be covered. We also have carefully evaluated HSA's impact on other categories of workers to see how they would fare under HSA: part-time workers, temporary employees, and seasonal workers.

a) Part-time Workers

We have generally found that HSA does a good job of addressing the needs of many part-time employees. Although part time workers would be required to pay some part of the employer's unpaid share, HSA's income-based caps would kick in to limit the total amount many part-time workers would have to pay towards their premiums. The type of part-time worker who will not fare well under the HSA is the part-time worker who works less than 40 hours a month for one employer. Such day workers or casual laborers would generally be responsible for the entire employer share (in addition to the family share), subject to income-based caps.

b) Temporary Workers

Temporary workers stand to gain significantly under the legislation because they would be considered employees—either part-time or full-time—of the temporary agency that hires and places them. Temporary agencies and employee leasing companies would be covered by the employer mandate and therefore be required to make employer contributions for each qualifying employee.

c) Seasonal Workers

The plan is most ambiguous in its coverage of seasonal workers. Theoretically, seasonal workers would be covered in the same way as other part-time or full-time employees, with employers being obligated to make contributions. However, the nature of seasonal work—with erratic work schedules that fluctuate widely from month-to-month (particularly for agricultural workers who move from employer to employer within a season of employment)—may mean these workers would fall through the cracks without any employer contributions.

Similarly, the plan does not adequately address the geographical or cross-regional alliance changes that inevitably happen during a work season for agricultural workers. A seasonal worker could lose coverage if she leaves an alliance for more than 6 months and does not join a new alliance.

In addition, even though the plan seeks to provide universal coverage, the HSA specifically excludes undocumented workers. Many farmworkers working for U.S. employers have no documentation. Many child care and elder care workers are also undocumented. By excluding undocumented workers, HSA denies coverage to these workers' families as well; indeed, even American-born children may be excluded from eligibility under the current proposal.

Civil Rights Protections

HSA contains many provisions that purport to ban discrimination by health alliances, health plans and states. While we emphatically agree about the need for such protections, unfortunately there are many shortcomings in the provisions contained in the bill. For example, some of the provisions fail to include sex as a protected class. Others ban intentional discrimination, but fail to ban conduct that has discriminatory effects. Few of the provisions apply to actions by regional and corporate alliances. Moreover, there is no provision for data collection to ensure that the entities governed or regulated by the HSA are in compliance with the antidiscrimination provisions.[23]

Research Priorities

HSA lists a few specific diseases or conditions that will require research: Alzheimer's disease, breast cancer, heart disease and stroke. It also list several more general categories research priorities: child and adolescent health (including birth defects); chronic and recurrent health conditions; reproductive health; mental health; elderly health; substance abuse; infectious diseases; health and wellness promotion; and environmental health.

While we do not take issue with the general categories listed in the legislation, more details about research priorities would be preferable. Important areas for re-

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[23] For a fuller discussion of the shortcomings of the HSA's civil rights provisions, see Testimony of Marcia D. Greenberger, Co-President, and Verna Williams, Senior Counsel, National Women's Law Center, before the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health and the Environment, January 31, 1994, presented on behalf of the National Women's Law Center and the Women's Legal Defense Fund.

search include: the effectiveness of existing cancer screening technologies and the development of better detection methods; contraceptive development; research on conditions that primarily affect women (such as osteoporosis and menopause); development of methodologies to account for women's reproductive capacities and other gender differences as variables in the conduct of research; and data collection and analysis adequate to assess gender differences in all research projects.

Confidentiality Issues

WLDF's major concern is that services be provided to family members confidentially. Confidentiality in medical care is essential, whether it is for an adolescent who needs birth control or treatment for a sexually transmitted disease, or for a woman in an abusive and faltering marriage who is unable to share with her husband information about a private medical condition.

There are no provisions in the HSA guaranteeing intra-family confidentiality. The confidentiality provisions in the bill deal with maintaining the privacy of information collected as part of the health information system established by the National Health Board. Intra-family confidentiality guarantees must be added to the legislation.

The stage is now set for what will be the most dramatic and far-reaching social reform this nation has experienced in decades. As we begin the very difficult and challenging process of defining and shaping the exact nature of these reforms, we must ensure that women's health care needs are adequately met.

This Subcommittee's willingness to listen to our concerns gives us hope that our needs and concerns will not become political fodder to be bargained away. We face an extraordinary opportunity to improve the health of the people in this nation, and with your continued help and vigilance we will not squander that opportunity.

Statement of the American Fertility Society

The American Fertility Society (AFS), an organization of more than 11,400 physicians and scientists specializing in reproductive medicine, is pleased to have this opportunity to comment on women's health as it relates to the Health Security Act. The AFS believes that meaningful health revision requires an emphasis on coverage for health maintenance and disease prevention as well as for the diagnosis and treatment of illness, including infertility.

An essential part of significant heath care reform is coverage for reproductive health services. These services include prevention of unintended pregnancy, sexually transmitted disease, infertility, gynecologic cancer, osteoporosis and cardiovascular disease. The services also include safe and effective treatment for infertility and other reproductive disorders.

The AFS applauds the President's decision to include coverage of reproductive health services in the Health Security Act. Family planning services are low-cost and cost-effective, and coverage should include counseling, contraception and sexually transmitted disease screening and treatment. We believe health reform must cover other essential preventive services like mammography and pap smears, the benefits of which have been well documented. The health plan for this country should provide coverage for pregnancy diagnosis, prenatal care, nutrition counseling, prescription drugs, labor and delivery and postpartum evaluation and services. We emphatically assert that these services should also include the diagnosis and treatment of infertility.

Infertility is a disease which affects the human reproductive system and can lead to an inability to have children. It affects one in every 12 couples. It is defined as a disease in which there is abnormal function of the reproductive system of either the male, female or both partners which requires indicated, not elective, treatment. The disease can be traced to medical problems in the female roughly a third of the time, medical problems in the male a third of the time, and a combination in both partners for the remaining third. We believe that any benefits package should include medically necessary and medically appropriate therapy for these infertile couples.

Left untreated, some infertility conditions can lead to serious health risks which will be more costly to treat down the road. For example, pelvic inflammatory disease can lead to scarring of the fallopian tubes, which can lead to the life-threatening condition of ectopic pregnancy.

Most infertility—85 to 90 percent—is treated with conventional medical and surgical therapy, from drug treatment to surgical repair of reproductive tract structures in both men and women. The majority of infertile couples require relatively low-cost conventional methods of treatment. Other treatment options include assisted reproductive technologies, standard clinical procedures which require the use of a labora-

tory to process human sperm and eggs. In vitro fertilization (IVF) is the most well-known of these techniques, although fewer than five percent of infertile couples who seek therapy are actually treated with IVE and other assisted reproductive technologies. The national health plan should provide coverage for both the conventional and assisted reproductive technologies.

In a letter from Dr. Judith Feder of the Department of Health and Human Services (attached), she states that "appropriate infertility diagnosis and treatment will be covered under the Health Security Act although they are not explicitly identified in the legislative language . . . The plan covers all services that a clinician has determined to be medically necessary or appropriate unless specifically excluded. The only infertility service excluded from the plan in vitro fertilization." Although this letter is reassuring that conventional infertility services are covered in the Clinton health care plan, they are not specifically mentioned and we would like to see the word "infertility" included in the bill.

The AFS is grateful that the diagnosis and treatment of infertility are now covered under the proposed Health Security Act. However, we are very concerned about the specific exclusion of in vitro fertilization services. We strongly believe that this exclusion should not be in the statutory language for the following reasons:

Exclusion will displace the medical decision-making process for medically necessary and appropriate procedures from physicians, patients, and the informed consent process.

Exclusion will cancel present IVE coverage provided to individuals in the states of Arkansas, Hawaii, Illinois, Massachusetts, Maryland and Rhode Island, and other individuals who have coverage for this benefit. Practitioners estimate that 30 to 40 percent of IVF cycles are partially or completely covered at this time.

Exclusion will deny access and availability to those in need, and will shift infertility management back to less effective and frequently more invasive and more costly procedures.

Coverage would add minimal costs to the benefits package. For example, mandated fertility coverage in Massachusetts accounts for four-tenths of one percent of the cost of the family package. In vitro fertilization services account for one-tenth of one percent of the package. There would be additional cost savings as a result of the reduction in the number of less-effective infertility services presently performed because they are covered by insurance.

In sum, providing benefits for reproductive health services is a vital part of any meaningful health system reform. Disease prevention—via mammography and other screening—clearly saves both lives and dollars. Family planning services are fundamental to preventive health care for women, since the ability to control the timing and spacing of pregnancy directly relates to the health and well-being of women. Moreover, the desire to parent is among the most fundamental desires of the human race, and is essential to the sustenance of society and the human spirit. Coverage for pregnancy-related services—including infertility diagnosis, treatment and in vitro fertilization will be an integral part of any health reforms enacted.

AFS is eager to help the Subcommittee on Aging determine what will be appropriate revision of the health care system. We applaud your involvement in this matter of great importance, and we thank you for the opportunity to comment.

Statement of Sandra Raymond

Madam Chair, my name is Sandra Raymond and I am the founding Executive Director of the National Osteoporosis Foundation. As you know, osteoporosis is a silent, bone-thinning disease which affects 25 million Americans. Eighty percent of those affected by osteoporosis are women, which is why osteoporosis stands as one of the three leading diseases of women. One in two women and one in five men will develop fractures due to osteoporosis, typically fractures of the hip and spine. It is a little known fact that a woman's risk of developing a hip fracture is equal to the combined risk of developing breast, uterine, and ovarian cancer.

In the 1990's, osteoporosis will result in 2.5 million hip and 5 million vertebral fractures causing pain, disability, deformity, loss of independence and death. Iii fact, 375,000 individuals will die due to complications resulting from these fractures. With hip fracture, the most serious consequence of osteoporosis, at least half of those able to walk before sustaining a hip fracture do not walk independently afterward. Their ability to care for themselves is compromised and their quality of life is reduced. Half of all hip fracture victims experience social deterioration and one-third may be totally dependent. For many women and older men, hip fracture is often the event that precipitates institutionalization.

Vertebral fractures are also disabling since compression of spinal bones cause not only deformity, but also the realignment of the body causing compression of the abdominal organs leading to difficulties in eating and swallowing and an awkward gait which may precipitate a fall leading to other fractures and pain.

Without interventions, the problem of osteoporosis will worsen as the population ages. In 1992, the acute care costs of one hip fracture was $40,000 and this figure does not include the long term care costs associated with this catastrophe. The direct and indirect costs of osteoporosis in the U.S. in 1992 were $10 billion. However, if we don't stop it now, these costs are expected to rise to $60 billion by the year 2000 and $200 billion by the year 2040.

Recently, the University of Southern California's Gerontology Center ranked osteoporosis, along with Alzheimer's disease, as potential federal "budget busters." If osteoporosis is not addressed through comprehensive programs of medical research and preventive health strategies, the costs of osteoporosis will swamp any efforts to contain rising health care costs.

Osteoporosis is a model for health care cost containment. The health care reform movement can begin to stem the tide of this national tragedy. While we cannot yet replace bone once it is lost, osteoporosis is an essentially preventable and treatable disease. We presently do have the means to greatly reduce the human and economic toll of osteoporosis.

The basic benefits package of a national health plan which strives to prevent disease before its onset must address osteoporosis.

We now have safe, effective, reliable, and accurate tests to measure bone mass. These noninvasive tests can detect low bone mass and accurately predict the risk of future fractures. These tests are even more predictive of a catastrophic event, such as hip fracture, than the blood pressure and cholesterol tests used to ascertain the risk of cardiovascular disease and stroke. A protocol for reimbursement is as follows:

Bone mass measurement tests are recommended to assist physicians in identifying those postmenopausal women and others at risk for osteoporosis in whom discovery of susceptibility is needed to decide upon treatment, and to monitor the effectiveness of that treatment. A single test is performed to define risk and a follow-up test is undertaken after an appropriate interval, e.g., 2-5 years, or as medically necessary, to monitor the efficacy of treatment.

A basic benefits package which includes early detection, treatment and management of patients with osteoporosis and osteoporotic fractures must include reimbursement of bone mass measurement tests and coverage for emerging biochemical tests to determine high risk populations, physician visits, medications, inpatient and outpatient rehabilitation services, and long-term care.

And, with an expanded federal medical research effort, osteoporosis will be brought under control. The present biomedical research program on osteoporosis is woefully inadequate. The lead Institute of the National Institutes of Health (NIH), the National Institute for Arthritis and Musculoskeletal and Skin Diseases (NIAMS), which has the responsibility for osteoporosis research, has never achieved parity with the other Institutes of Health. Outstanding peer reviewed research grants on osteoporosis are not being funded due to the extremely low payline of this Institute.

The NIAMS payline for osteoporosis grants is around the 12 percent level whereas the average payline for NIH is 25 to 26 percent. With a reasonable biomedical research effort, experts in the field agree that osteoporosis can be brought under control in the next decade. While the NIH Revitalization Act of 1993 authorized $40 million in new funds for osteoporosis research, no new funds for this purpose were appropriated by Congress in FY 1994. Current federal spending on osteoporosis research is little more than $1 per person affected by the disease.

In closing, a comprehensive national strategy to address osteoporosis, which includes a coordinated program of research, health policies, insured coverage for osteoporosis services and a program of public education to alert the American people to the consequences of this silent, devastating disease must be established in FY 1994.

Thank you.

Statement of Diane Aronson

Chairwoman Mikulski and Members of the Subcommittee, RESOLVE is pleased to submit this testimony on behalf of its 25,000 members and the 5.3 million Americans who suffer from the disease of infertility. We are very supportive of your efforts to reform this nation's health care system which currently discriminates against the infertile by frequently denying them coverage for medically appropriate treatment.

I will use this opportunity to provide the Subcommittee with some important information about infertility and to urge the Subcommittee to include comprehensive infertility diagnosis and treatment in any benefit package enacted as part of national health care reform.

RESOLVE is a national, nonprofit organization established in 1974 to provide support, education and advocacy for infertile couples. Today we have 56 chapters across the country. Our national HELP LINE receives hundreds of calls annually from people needing information about various treatments or clinics and those seeking help with the emotional trauma of infertility. Our local chapters offer support groups run by trained therapists, educational seminars on infertility developments and treatments, information on adoption and child free living, and advocacy efforts at the state and federal levels.

RESOLVE's membership is very pleased that the Clinton Administration has included most infertility treatment in the benefit package of the Health Security Act (HR 3600). I have attached a letter from Dr. Judith Feder, Principal Deputy Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services, which specifies that ". . . appropriate infertility diagnosis and treatment will be covered under the Health Security Act although they are not explicitly identified in the legislative language." We are dismayed, however, that Dr. Feder goes on to state, "The only infertility service excluded from plan coverage is in vitro fertilization." RESOLVE strongly believes that totally excluding in vitro fertilization (IVF) from coverage is medically and fiscally irresponsible since it is the most medically appropriate and cost effective treatment for some forms of infertility. I will return to the subject of in vitro fertilization later in this testimony.

First I would like to give you some important facts about infertility, a disease of the reproductive system that is greatly misunderstood by the general public because, unless faced with this condition, most people have given it little thought. Media stories have helped to create misperceptions by attempting to sensationalize a real and tragic problem. Numerous stories printed or aired recently have been poorly researched and contained erroneous information. Following is factual information that I hope will enhance your understanding of infertility which is a serious medical condition that exacts an enormous toll on those who suffer from it, their families and friends, and society as a whole.

DEFINITION AND SCOPE OF INFERTILITY

Infertility is a disease or malfunction of the male or female reproductive system. A specific medical problem can be identified in 80 percent of all cases of infertility. The other 20 percent includes cases in which a combination of problems are present or the cause of the infertility cannot be isolated. The reproductive system is one of the major systems in the human body. Diagnosis and treatment of reproductive problems should be covered by health care insurance just as problems with the digestive system, respiratory system or muscular system are covered. Infertility is not a life style choice; medical treatment for this disease is not elective.

Infertility affects 5.3 million Americans, or approximately 10 percent of the reproductive age population. This means that one out of every six couples in this country will face an infertility problem of one kind or another.

Men and women suffer equally from infertility. Male factor infertility accounts for fifty percent of identifiable problems (low sperm count, poor sperm motility, hormonal imbalances, deformities in the reproductive organs, and other abnormal functioning). Female factor also accounts for fifty percent of identifiable difficulties (ovulation problems, fallopian tube damage or disease, hormonal imbalances, ovarian tumors or cysts and other abnormalities). These conditions can be diagnosed and medically appropriate treatments, ranging from simple drug therapy to corrective surgery or in vitro fertilization, can be used with successful outcomes, that is, pregnancy, possible about half the time. According to a federally funded study published in July 1993,[1] more than 98 percent of people with infertility can be treated by conventional drug and medical/surgical procedures; only 1.2 percent use IVF.

Infertility affects a very broad range of people. It knows no boundaries of For example, the children of mothers who took DES (diethylstilbestrol) have an increased incidence of infertility. Adult males who contract mumps may become sterile. Some asthma sufferers take a drug that can cause infertility. Environmental pollutants can adversely affect reproduction. No group or individual is immune from the possibility of not being able to create a biological family on their own.

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[1] Use of Fertility Services in the United States, Lynne S. Wilcox, MD, MPH, and William D. Mosher, PhD., Obstetrics and Gynecology, Vol. 82, No. 1, July 1993.

RATIONALE FOR INCLUDING IN VITRO FERTILIZATION

IVF is a proven, nonexperimental, medically appropriate and necessary treatment for some forms of the disease of infertility. The procedure has been used for fifteen years, has produced over 23,000 babies in the United States alone and is considered a standard part of the continuum of infertility treatments. Covering infertility treatment but excluding IVF—the only specific medical protocol on the exclusion list—is like covering heart disease through a triple bypass, but excluding coverage if a quadruple bypass is needed. Excluding IVF is unfair and will result in the two tier system of health care that President Clinton is trying to avoid by making it available only to those who can afford to pay for it privately. It is also not justified by the facts and experience of IVF treatment over the past decade.

Fewer than 2 percent of people suffering from infertility use IVF; more than 98 percent are treated with more conventional therapies. For this group of patients, however, IVF is medically appropriate and necessary. In some cases it is the only treatment available. IVF is most commonly used to treat women with blocked, damaged or absent fallopian tubes. For these women IVF is the simplest, most successful and most cost-effective treatment. It allows the physician to remove the eggs from the ovary, inseminate them in a petri dish (the term "test tube" baby is incorrect), and place any resultant embryos directly into the woman's uterus thus bypassing the absent or destroyed tubes. Sometimes women with this problem choose to undergo one or several tubal surgeries which is more expensive, riskier to the patient and less successful in terms of pregnancy outcome. It is often the only choice, however, because most insurance will pay for tubal surgery but not for IVF. IVF is the cost-effective and more medically appropriate alternative.

IVF has a good success rate. The rate of success for IVF is 15-20 percent per cycle. For women whose primary diagnosis is fallopian tube problems, the success rate is even higher. When compared to the 20-30 percent chance that a reproductively healthy couple has of achieving a pregnancy in any given cycle, the IVF pregnancy rate is quite good.

Excluding IVF will result in a loss of benefits currently available in States that now mandate infertility coverage. Ten States now have mandates that require insurance companies to cover or offer coverage of infertility treatment. In addition, some employers voluntarily offer infertility coverage to their employees. If the national benefit plan specifically excludes IVF, some residents of these states will lose benefits that they already have. President Clinton has stated many times that no one should be worse off under his plan than before it. That would surely not be the case if IVF remains on the exclusion list.

Legislating the exclusion of IVF, a specific medical protocol, is neither good medicine nor good public policy. A piece of legislation that will be law for several decades, if enacted, is not the place to determine which specific protocols doctors may use. In vitro fertilization is one of many treatments for infertility and is appropriate and necessary for certain cases. No medically appropriate treatment for the disease of infertility should be excluded from the benefit package.

In recent months the media have reported extensively on a number of new ideas in the field of reproductive endocrinology. We have read about attempts to "clone" embryos (not really what the experiment was about), about women having babies beyond their reproductive years, about the potential of using fetal eggs as donors. All of these procedures or potential procedures would require the use of IVF technology. RESOLVE's position on these developing technologies is that insurance need not cover any experimental procedure. But these extreme instances of IVF usage should not be allowed to deprive hundreds of couples in their childbearing years who might achieve the goal of biological parenthood through IVF from having access to it.

THE COST OF INFERTILITY TREATMENT

The cost of infertility treatment varies greatly from patient to patient depending on the diagnosis and the treatment required. For those needing only a mild hormone drug the cost will be minimal, while those needing tubal surgery will have a significantly higher bill. Couples who remain in treatment for many months or who pursue treatments like IVF can expend tens of thousands of dollars on the quest for biological family

The critical point as deliberate about health care reform, however, is what is the cost to the U.S. health care budget. Perhaps the best laboratory we have to study what potential costs will be is to look at the experience in the State of Massachusetts. Since 1986 Massachusetts has mandated that all insurers cover comprehensive infertility diagnosis and treatment including unlimited cycles of IVF. In a letter to RESOLVE dated June 4, 1993 Nancy C. Turnbull, then First Deputy Commis-

sioner for the Division of Insurance of the Commonwealth of Massachusetts, stated that all infertility coverage accounted for "four-tenths of 1 percent of the total monthly family premium." Factoring out the cost of IVF based on fewer than 2 percent of patients means that the cost attributable to IVF would be in the hundredths of a single percentage point.

In short, there is no justification based on experience to exclude IVF because of cost. In fact, it is fiscally unsound since some patients are undergoing more expensive, less effective procedures because they cannot afford to pay privately for IVF. There would be a definite savings from less tubal surgery if IVF were covered by insurance.

SUMMARY

Our society places great value on families and there may be no greater instinct in the human species than to create wanted children. When a diagnosis of infertility is made it is a shock to a couple and shakes one of the most basic assumptions we all grew up with: that one day we would become parents. An enormous emotional toll is exacted by infertility as the rollercoaster ride of hope and disappointment goes on for months and even years. In addition to the often arduous rigors of the physical treatment and the emotional upheaval, infertile Americans should not also have to struggle with the financial burden of treatments that are arbitrarily omitted from insurance coverage for no reason based in fact or experience.

We have been told that infertility is not life threatening. But nor are most of the reasons people seek medical care. What people are concerned about is the quality of life and the relief of pain. The quality of life for an infertile couple can be just as severely impaired as that of someone suffering from back pain or requiring arthroscopic surgery or any one of thousands of non-life threatening conditions covered under the national benefit package. The pain of infertility is real and consuming. There is nothing elective about infertility. It is insulting to infertile people to see in vitro fertilization listed with cosmetic surgery and private room accommodations on the exclusion list.

RESOLVE supports health care reform. We believe that all Americans should have access to the medical care they need. The Administration's bill is a step forward where infertility coverage is concerned, but the exclusion of IVF mars our enthusiasm. Medical technology can now offer people who suffer from infertility a chance to have a family. It is unreasonable and unnecessary to restrict access to IVF treatment for those who can benefit from it. Any national benefit package should include all nonexperimental infertility services including IVF. It will not add significantly to the cost of the package, but will add immeasurably to the lives of those wishing for a child.

I thank the Subcommittee for its interest and hope that we can count on you to include comprehensive infertility treatment, including IVF, in whatever health care plan is passed by the Subcommittee and enacted into law.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
WASNINGTON, DC. 20201,
November 16, 1994.

Ms. DIANE D. ARONSON,
Executive Director,
RESOLVE,
1310 Broadway,
Somerville, MA 02144-1731.

DEAR MS. ARONSON: Thank you for writing regarding RESOLVE's concern over coverage of infertility services in the comprehensive benefits package of the Health Security Act.

I understand from your letter that you are concerned that the wording of one category of covered services in the comprehensive benefits package, "Family Planning and Services for Pregnant Women," may result in the exclusion of infertility services.

Please be assured that appropriate infertility diagnosis and treatment will be covered under the Health Security Act although they are not explicitly identified in the legislative language. The comprehensive benefit package under the Health Security Act has broad definitions that will assure coverage for services not itemized in the Act, such as infertility services. The plan covers all services that a clinician has determined to be medically necessary or appropriate unless specifically excluded. The only infertility service excluded from plan coverage is in vitro fertilization.

The Health Security Act lists "Family planning services and services for pregnant women" as a distinct category of services in the comprehensive benefit package to emphasize the importance of family planning and perinatal care within the plan. This benefit distinction does not signify the prohibition of other services that do not fall within the category.

Thank you for expressing your concerns and for your interest in the Health Security Act. We appreciate your support of President Clinton's health reform plan.

Sincerely,

JUDITH FEDER,
Principal Deputy Assistant Secretary,
for Planning and Evaluation.

STATEMENT OF THE NATIONAL WOMEN'S LAW CENTER

HOW WOMEN FARE UNDER CLINTON HEALTH CARE REFORM

Health care reform provides an opportunity to address the health care crisis facing so many American women. For decades, their health care needs have been overlooked, underfunded and cut out of many health care programs. With women and their children disproportionately represented among the uninsured, universal coverage is critical to women. Even when available, health care is often unaffordable for some women both because women's earnings are only about 70% of men and because women are disproportionately represented in jobs paying under $20,000 where 93% of uninsured workers are concentrated. Thus, affordability is essential. Because insurance reimbursement often denies women access to nurse practitioners and other providers of choice, provider choice is a priority for women. The bias in our current system against preventive care and the patchwork treatment of reproductive health services makes comprehensive benefits a key component of any reform package. And finally, with the exclusion of women's voices in many decision-making forums and vital women's treatment needs often ignored, accountability and non-discrimination provisions to address these problems are essential. In short, because there are so many ways in which women's needs have not been met under our current health care system, the stakes for women in health care reform are very high.

SUMMARY

President Clinton's health care reform package offers major advances for women and their families, improving in key respects women's access to universal coverage, affordable care, choice of providers, comprehensive benefits and provisions ensuring accountability and barring discrimination. For women, the Clinton plan will be a significant improvement over the current system. There are however, some areas where clarifications and changes are still needed to ensure that the bold reforms promised by the plan are a reality for all women. Highlights include:

UNIVERSAL COVERAGE

An employer mandate assures that women, regardless of their employment, income or marital status will receive health insurance;

Dependents and part-time workers are included and coverage doesn't lapse when employment or marital status changes;

But, provisions governing homemakers and children in three generation families still need clarification, and neither undocumented workers nor prisoners are covered.

Affordable Coverage and Choice of Providers—A number of provisions will help to assure that coverage is affordable and consumer choice retained. For example:

Individuals, not employers make the selection of a health plan;

There are caps on costs to individuals in the form of limits on premium increases and annual out-of-pocket expenses;

Premium subsidies will help low-income individuals up to 150% of poverty purchase coverage;

Community rating will eliminate the common practice of charging women more than comparably situated men;

But, the subsidies are inadequate, limiting the ability of some low-income women to purchase needed services; steep cost sharing requirements particularly in the form of co-pays could make care unaffordable for some; and some pregnant women on Medicaid will lose enhanced pregnancy related services.

Comprehensive Benefits are assured through a guaranteed benefit package based on a broad standard:

Clinieal preventive services including routine check-ups, and mammography and pap smear screening are available on fixed schedules at no cost;

A full range of reproductive health care services are covered;

Important steps are taken on mental health and long-term care services;

But, the mammography schedule falls short of many expert recommendations, and family planning services are not considered preventive services and hence are subject to co-pays and deductibles that will make them unaffordable for some.

Civil Rights and Public Accountability—Key civil rights provisions lay the groundwork for assuring that discriminatory practices are prohibited:

Health plans are expressly prohibited from discriminating against many protected groups including women;

Some enforcement mechanisms are similar to other civil rights laws;

But, outside the health plans, the provisions do not consistently prohibit sex discrimination, leaving women unprotected with regard to the states, the health board and regional alliances. Also, better preclearance and other enforcement mechanisms are needed.

[Additional material may be found in the files of the committee.]

STATEMENT OF ANNE L. BRYANT

The American Association of University Women (AAUW) strongly supports the creation of a national health care system that ensures comprehensive and quality health care coverage for all Americans at an affordable cost. As an organization committed to improving the social, physical, and economic well-being of all individuals, AAUW believes that quality health care is a right, not a privilege.

Integral to achieving the goal of universal access to health care is availability of a wide range of service providers reaching as much of America's diverse population as possible. The creation of a health care continuum, from early childhood to old age, will require putting services where individuals and families can take advantage of them. AAUW believes that the schools must be key players in the provision of health services for children, and that school-based or school-linked clinics should be eligible for reimbursement by health care plans.

Services provided in a school-linked setting would improve both the health and educational performance of America's neediest children. It is obvious that students who suffer from depression or malnutrition, who become pregnant or have drug or alcohol problems cannot take full advantage of the educational programs available to them. And while coordination of services and health education would benefit all students, it has particular relevance to the lives and educational experiences of girls.

In 1992, the AAUW Educational Foundation released The AAUW Report: How Schools Shortchange Girls, highlighting a variety of issues that have an impact on the opportunities of girls to succeed in school and beyond. Among them were health needs currently given little attention and resources in most school systems. As this subcommittee reviews the President's and other alternative health care reform plans, AAUW urges that the needs of girls and young women, who represent 53 percent of the student population, be carefully considered and addressed.

Contraceptive Use and Sexually Transmitted Diseases (STDs)

The HIV infection rate for teenage girls is comparable to, and in some cases higher than, that for boys. While among adults, male AIDS cases are nine times more prevalent than female cases, the pattern of HIV infection among adolescents is very different. A 1989 study in the District of Columbia reports the HIV infection rate at 4.7 per 1000 for girls, almost three times the 1.7 rate for boys.

Comprehensive health education must be taught in all our nation's schools and must cover contraceptive use. STD counseling and contraceptives should be encouraged in school-based clinics to reverse this alarming trend.

Pregnancy

Research shows that nearly one-quarter of the school dropout rate is attributable to teen pregnancy. Nearly half of the girls who drop out do so because they are pregnant or have one or more children, making pregnancy a pressing educational issue, for young women and for the welfare of future generations. A mother's educational level is universally known to be one of the best indicators of her child's academic success. Children raised by mothers who never complete high school experience higher rates of academic failure and behavioral problems. Over half of all mothers now on welfare bore their first child as a teenager. Pregnancy prevention must be an integral part of health education programs and health services.

Health services for students who are already pregnant are also critical. Fully one-quarter of pregnant mothers receive no medical care of any sort during the crucial

first trimester of pregnancy. About 20 percent of children with disabilities would not have that disability had their mother had one physical exam during this period (Phi Delta Kappan 9/91). The United States has a higher infant mortality rate than Japan, Canada, and most European countries, according to a recent report; the rate is particularly high for African American infants.

Every dollar spent on prenatal care saves $3.38 in the cost of caring for low birth weight babies. This is just one example of how putting health services in the schools can reach a needy segment of the population and make better use of scarce funding.

Eating Disorders

Food bingeing and chronic dieting are, sadly, a regular feature of the high school, junior high, and even upper elementary school landscape. A 1989 National Adolescent Health Survey of 10,000 public school students found that 61 percent of girls reported having dieted in the past year, compared with 28 percent of boys. Half of those who dieted had fasted as a means of weight loss. Girls are also more likely than boys to report vomiting to control their weight and to abuse over-the-counter appetite suppressants Severe cases of bulimia and anorexia nervosa can cause death.

Diet counseling, nutrition and exercise information, and health education programs that consciously promote positive self-image can help combat forces in society that wreak havoc on girls' self-esteem.

Depression and Suicide

Shortchanging Girls, Shortchanging America, a study published by AAUW in 1991, found that girls' self-esteem drops dramatically as they move through adolescence. other research shows that females have higher rates of depression than males, during both adolescence and adulthood. Severely depressed girls have been shown to have higher rates of substance abuse than similarly depressed boys. Significant gender differences were also found in school performance measures among the most depressed students: grade point averages were lower for girls, and 40 percent more girls failed a grade than boys. Adolescent girls are four to five times more likely than boys to attempt suicide (although boys, who choose more lethal methods, are more likely to be successful in their attempts).

RECOMMENDATIONS

Suggested Health Services: AAUW respects the importance of flexibility for grant recipients in deciding what services to offer and with whom to coordinate provision of services. However, we are also painfully aware that unless specified1 the needs of females are often not met by school systems, in or out of the classroom. We urge greater specificity in listing the kinds of services to be provided by these initiatives. Services must include: pregnancy-related services, contraception, maternal and child health, lab and testing services, and counseling and information on eating disorders, nutrition, substance abuse, sexually transmitted diseases (including AIDS), and depression and suicide.

Comprehensive Health Education: AAUW advocates the promotion of comprehensive K-12 age-appropriate health education programs. Curricula should recognize and address the different needs of female and male students and actively seek to improve the self-image and self-esteem of students.

Referrals: School-based clinics should be given flexibility in the kinds of services they provide and be able to refer students to other easily-accessible health service providers where necessary.

Enabling Services: AAUW commends the Clinton Administration's inclusion of "enabling services," which increase the capacity of individuals to utilize the services in the comprehensive benefits package. Transportation is a key access issue for many young women and girls. We also urge that dependent care assistance, which was not listed in the Clinton bill, be Specified in any health care reform plan.

Suggested Partners: AAUW urges inclusion of a list, in the section describing contents of the grant application, of Suggested agencies and service providers that should be considered for partnership or advisory status. Certain segments of America's population seem continually at risk of being forgotten or excluded, unless attention is called to them early and often. A list of suggested partners should include juvenile justice workers, social workers, legal services offices, WIC and Welfare administrators, and service providers for migrant children, recent immigrants, and parents and children with limited English proficiency.

CONCLUSION

Throughout the health care reform process, AAUW will continue to work to ensure that women's health needs are recognized and met. AAUW believes that the

provision of health services in a school-based or school-linked setting, if sensitive to the needs of all students, is a critical "jumping-off point" for a lifelong system of comprehensive health services. We urge this subcommittee to help ensure that the needs of all students are recognized by those community leaders who will be planning and implementing this crucial aspect of health care reform.

Prepared Statement of Jeannie I. Rosoff

Good morning. My name is Jeannie Rosoff, and I am President of The Alan Guttmacher Institute (AGI), a not-for-profit corporation for reproductive health research, policy analysis and public education. I am pleased to be here today to talk with you about the opportunity presented by health care reform to ensure adequate insurance coverage for women's reproductive health care needs.

Adequate coverage of the full range of reproductive health care services is critical for two reasons: first, because a woman's reproductive years span half of her entire life and, second, because this period is not static but encompasses several stages during which both her reproductive goals and her health care needs change. For example, during the several years in which the typical young woman is sexually active before she wishes to become pregnant, she is likely to need contraceptive services to avoid unwanted pregnancy as well as routine gynecological care that includes screening for sexually transmitted diseases and cancers of the reproductive system, in order to protect her general reproductive health and ensure fertility in the future. During the relatively few of her reproductive years in which the typical woman is pregnant or trying to become pregnant, she should receive a preconception risk assessment and comprehensive maternity care, including prenatal, delivery and postnatal care. A woman confronting an unintended pregnancy may choose to have an abortion, while a woman who has completed her desired family size may seek a contraceptive sterilization. And, a woman unable to conceive may desire infertility services.

To meet women's varied and changing health care needs, then, a reproductive health care package, in order to be truly comprehensive, must include all of these services. While not every woman will need all of them over the course of her life, most women will need many of them at one time or another.

It is important that these reproductive health services be seen as important not only in their own individual right, but also in their critical relationship to one another. For example, family planning services are related to the achievement of good birth outcomes, while screening and treatment for STDs are important to preventing infertility. Finally, many of these reproductive health services are needed by men as well as women. Ensuring good reproductive health, and good reproductive outcomes, should not be just be a woman's responsibility, a woman's burden.

The AGI Insurance Study

Much is known about the coverage of reproductive health care services through public programs. Unfortunately, much less has been known about the private-sector, employment-related insurance that provides coverage to two-thirds of women of between the ages of 15 and 44[1].

Understanding current patterns of coverage is necessary if we are to transform the existing financing patchwork into an insurance system that truly meets women's health care needs. This is particularly true since any such new system is likely to draw heavily on existing private-sector coverage, making it critical that we know what about current coverage is good and should be retained, and what needs to be improved.

For these reasons, AGI last year undertook the first large-scale study of private insurance coverage of reproductive health care services. In an attempt to obtain a comprehensive picture of the different kinds of coverage American women have, we cast a wide net, surveying the 100 largest commercial insurance companies, all 73 Blue Cross-Blue Shield Plans, all 106 HMOs with 100,000 or more enrollees and a sample of 107 smaller HMOs. The survey -- which was developed in conjunction with a panel of experts in the health care and employee benefits fields -- was completed by 58 percent of the commercial companies for whom it was applicable,[2] 53 percent of the applicable Blue Cross-Blue Shield plans and 50 percent of the HMOs surveyed. Altogether, a total of 189 responses are included in the analysis. These results are accurate within 10 percentage points or less, with 95 percent reliability. (A detailed discussion of the methodology is attached.)

This study -- supported by the Robert Wood Johnson Foundation and conducted by AGI Policy and Research Associates Rachel Benson Gold, Daniel Daley and Jennifer Frost -- addresses three issues critical to ensuring that people not only are insured for, but also are able to access, the care they need: whether specific reproductive health care services are covered, whether plans have provisions for patients to obtain confidential care and the ease with which patients can access services in a managed care environment. The full study will be released mid-year.

Because the study is still in progress, we were able for this hearing to analyze data only relating to the first issue -- the extent to which reproductive health services are covered -- and to concentrate only on a few key services out of the 25 we will be considering in the final report. I want to stress, however, that all aspects of the study are critical to a comprehensive understanding of the full range of women's reproductive health insurance needs and the extent to which they are being met.

To address the coverage issue, survey respondents were asked to indicate whether each of the services in question is typically[3]

- covered when considered medically necessary or appropriate by the physician ("routinely covered");
- covered only when additional requirements are met; or
- not covered at all.

Recognizing that health insurance comes in many forms in the United States today, we asked the question concerning a wide range of employment-related insurance policies: insured indemnity plans written for groups of under 100 employees, insured indemnity plans written for groups with 100 or more employees and self-insured plans (which together account for 58 percent of insured employees) as well as Preferred Provider Organizations (which account for 20 percent), Point of Service networks (which account for 3 percent) and HMOs (which account for 19 percent)[4].

For purposes of our discussion here today, the numbers I am going to cite will be for insured plans written for large groups, contrasted with HMOs.[5] We have chosen to cite data for large-group plans because, as you can see from the attached tables, there are not many differences among the various types of fee-for-service plans and because large-group plans are the ones that insure most Americans.

Key Findings

We began this project with an understanding of the historic traditions of private-sector health insurance coverage -- generally to provide coverage of surgical services and not to cover preventive care. What we found is that these traditions remain strong today. Considering how much of reproductive health care is preventive in nature, the impact of these traditional patterns on coverage, especially coverage of contraceptive services, is significant and distressing.

- Sterilization and Abortion

Not surprisingly, given traditional practices, surgical reproductive health care services are well covered in typical insurance policies. Sterilization services are routinely covered by at least 85 percent of all types of typical insurance policies. Coverage of abortion follows much the same pattern.

Coverage of abortion services is widespread in all types of health insurance policies. Approximately two-thirds or more of all the types of policies included in this survey -- including 66 percent of large-group fee-for-service policies and 70 percent of HMOs -- routinely cover abortion in their typical plans.

Nonetheless, it is worth pointing out that many plans also place restrictions on the coverage of abortion services. In addition to those plans that routinely cover abortion, nearly one-quarter of large-group plans and one-fifth of HMOs restrict coverage, generally by requiring the provider to certify the presence of a specific medical indication (beyond pregnancy itself) for the procedure. Finally, only 11 percent of large-group plans and 10 percent of HMOs typically do not cover abortion services at all.

- Reversible Contraception

In sharp contrast to the extensive coverage of sterilization and abortion services, but clearly in line with the traditional bias of health insurance against preventive care, coverage of reversible contraception -- particularly, but not exclusively among indemnity plans -- is insufficient, at best.

None of the five reversible methods included in the survey -- IUDs, Diaphragms, Norplant, DMPA (Depo Provera) injection and oral contraceptives -- is routinely covered by any more than 40 percent of typical plans. Half of the large-group plans typically do not cover any contraceptive method at all (59 percent of typical policies written by commercial companies and 36 percent of those written by Blue Cross-Blue Shield Plans). Only 15 percent cover all five methods (8 percent of commercial companies and 24 percent of Blue Cross-Blue Shields). The extent to which individual contraceptive methods are covered in large-group policies varies significantly in some cases between commercial companies and Blue Cross-Blue Shield Plans; Blue Cross-Blue Shield Plans are significantly more likely to cover IUD insertion, diaphragm fitting and Depo Provera injection than are commercial companies.

Oral contraceptives, the most commonly used reversible method, are routinely covered by only one-third of large-group plans.[6]

The failure of plans to cover oral contraceptives is not the result of an overall failure to cover prescription drugs. While 97 percent of large-group plans typically include coverage of prescription drugs, two-thirds of these plans do not routinely cover oral contraceptives.

Along the same lines, while over 90 percent of large-group plans typically cover medical devices in general, more than 80 percent of these plans do not cover IUDs or diaphragms, and three-fourths do not cover the Norplant device. Only 24 percent of plans routinely cover all three components of Norplant -- the device itself as well as insertion and removal.

Once again, the tradition of covering surgical care becomes evident. Forty-three percent of large-group plans that cover tubal ligation routinely cover no reversible contraceptive method at all (50 percent of plans written by commercial companies, 36 percent of Blue Cross-Blue Shields).

HMOs provide somewhat more comprehensive coverage of contraception than do fee-for-service plans. Only 7 percent of HMOs provide no contraceptive coverage at all, and 40 percent cover all five methods. Coverage across the various methods ranges widely, however, from 59 percent for Norplant insertion to 86 percent for IUD insertion. Eighty-four percent routinely cover oral contraceptives.

- Counseling and Risk Assessment

Coverage of the support services women need to be able to make informed choices about their reproductive lives is also meager. Only 22 percent of large-group plans routinely cover contraceptive counseling (13 percent of commercial companies and 33 percent of Blue Cross-Blue Shields), while only 43 percent routinely cover preconception risk assessment. In contrast, each of these services is routinely covered by at least 90 percent of HMOs.

Implications

What emerges from these findings -- limited as they are --is a portrait of private insurance coverage that is antiquated in its bias toward surgical care over nonsurgical procedures, curative care over preventive care and medical procedures over counseling and education. These patterns of coverage leave women with little or no coverage for key services they need during their childbearing years. Our emerging national health care reform plan must not model itself on current capricious patterns of coverage that simply do not address the needs and circumstances of women and couples today.

As we undertake to fashion a new system, one that builds on and improves the current situation, we should keep three things in mind. First, even as we extend to people coverage they do not now have, we must not take away coverage -- such as the coverage of abortion or sterilization -- that is already widespread. Both of these services are critical to the lives of many women and couples. One half of all pregnancies in the United States are unintended, and half of women confronting an unintended pregnancy choose abortion. By the same token, sterilization is the contraceptive method of choice among couples over age 30. Coverage of these important services must be retained.

Second, even as we retain coverage of abortion and sterilization, we must radically expand coverage of contraceptive services. Our study clearly demonstrates that, in order to achieve this end, we will need to be specific. In this sense, the Clinton plan -- despite its apparent intention to provide comprehensive family planning coverage -- falls short. For example, it relies on the general coverage of prescription drugs to assume the coverage of oral contraceptives. What we have learned from our study is that such an assumption is unwarranted: two-thirds of plans that cover prescription drugs now nonetheless do not routinely cover oral contraceptives.

In that same light, reliance on the general term "family planning services," without amplification, to ensure adequate coverage is also insufficient. As with other services spelled out in the bill, family planning services should be clearly defined. There are many models that could be used for this definition, including the one used by the Health Care Financing Administration for purposes of giving guidance to states claiming federal reimbursement under the Medicaid program.[7] The bottom line is that only this specificity will ensure that coverage intended becomes coverage actually provided.

Finally, let me express our concern over the failure of the Clinton plan to classify family planning as a clinical preventive service. Family planning is a quintessential preventive service; its role in reducing unintended pregnancy, and hence the need for abortion as well as our unacceptably high levels of infant mortality, is undeniable. It is estimated that publicly subsidized family planning services alone prevent 1.2 million unintended pregnancies each year -- 516,000 of which would have ended in abortion and 509,000 in unintended births.[8] The National Commission on Infant Mortality estimated that 10 percent of infant deaths nationwide could be prevented if all women not desiring pregnancy had used contraception.[9] The failure of the Clinton plan to formally designate family planning as the preventive service it is leaves family planning -- alone among preventive services -- subject to deductibles and copayments.

In closing, let me say that we are glad to have been able to accommodate the Committee and provide you with key findings of our forthcoming study. We will, of course, provide the full report as soon as it is available. In the meantime, I am pleased to respond to any questions you may have.

[1] Women's Research and Education Institute, Women's Health Insurance Costs and Experience, 1994.

[2] Some private insurance companies included in the survey indicated that the survey was not applicable to their business either because they only write either nongroup coverage or policies specifically designed to supplement Medicare coverage.

[3] For purposes of this project, "typical is defined as that which represents the coverage written for most of the lives covered by each policy type or by the individual HMO.

[4] Marianne Miller and Thomas Dial, Employer-sponsored Health Insurance in Private Sector Firms in 1992, Health Insurance Association of America, August 1993.

[5] In general, the data will group commercial companies and Blue Cross-Blue Shield Plans together; when the differences between the two are significant, the data for each are cited.

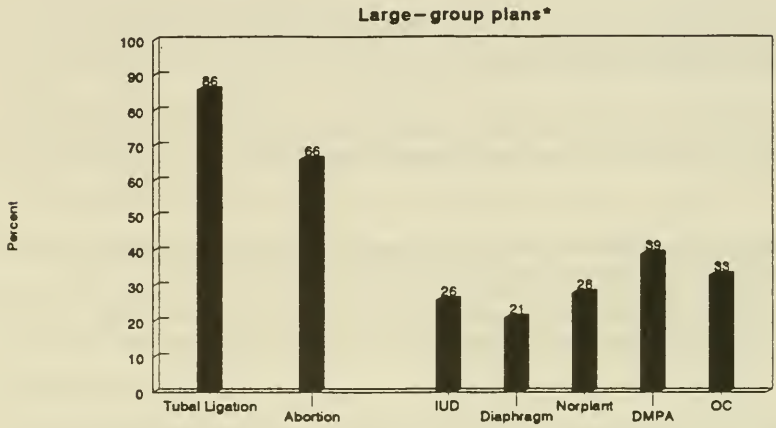
[6] An additional 8 percent of typical plans include restricted coverage of oral contraceptives, generally covering them as a treatment for a specific medical problem such as menstrual irregularities but not for purposes of contraception.

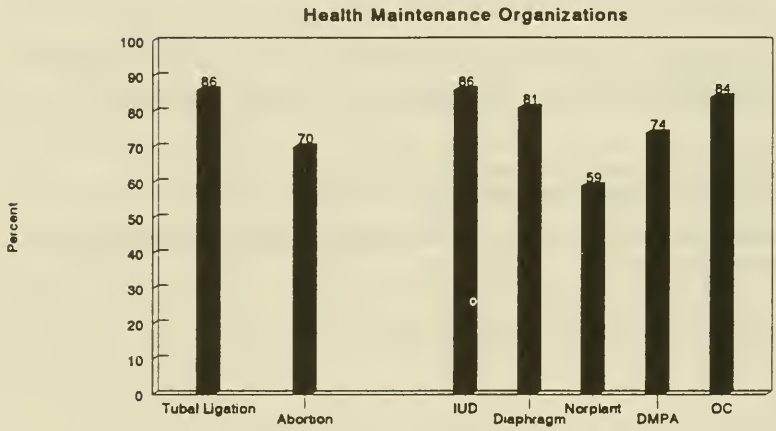
[7] On its quarterly HCFA-64 form, HCFA considers family planning to be "consultation (including counseling and patient education), examination, and treatment, furnished by, or under the supervision of, a physician or prescribed by a physician; laboratory examination; medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception; natural family planning methods; diagnosis and treatment for infertility; and voluntary sterilization and drugs."

[8] J.D. Forrest and S. Singh, "Public-Sector Savings Resulting from Expenditures for Contraceptive Services," Family Planning Perspectives, 22:6, 1990.

[9] National Commission to Prevent Infant Mortality, Troubling Trends: The Health of America's Next Generation, February 1990.

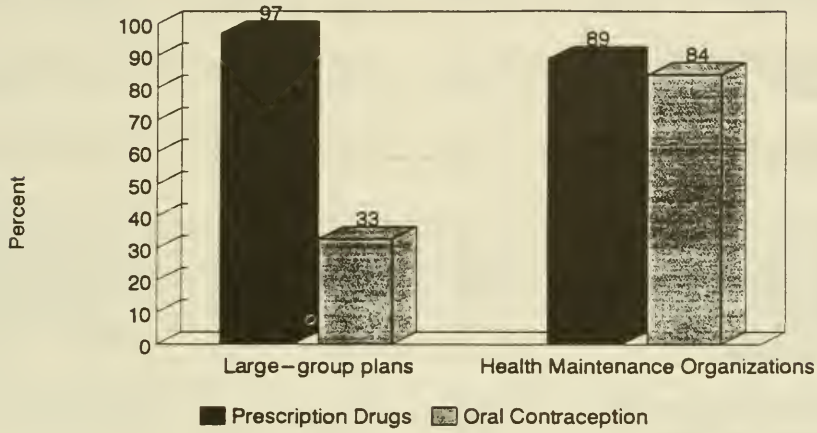
Percent of typical large–group plans* and HMOs routinely covering sterilization, abortion and reversible contraception



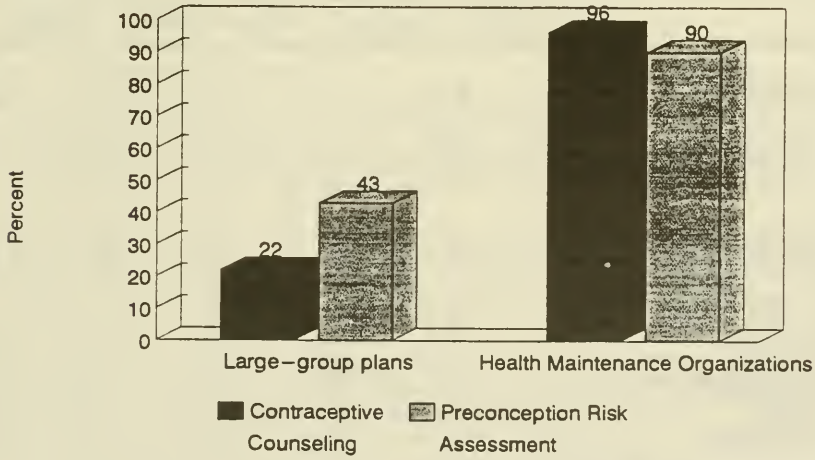


* Insured indemnity plans written by commercial insurance companies and Blue Cross/Blue Shields for groups of 100 or more employees.

Percent of large–group plans* and HMOs that routinely cover prescription drugs and oral contraceptives



Percent of large–group plans* and HMOs that routinely cover contraceptive counseling and preconception risk assessment



* Insured indemnity plans written by commercial insurance companies and Blue Cross/Blue Shields for groups of 100 or more employees.

Percent of typical plans in which specific service is routinely covered, by type of plan

Service	Conventional Indemnity Plans, by size of group			Preferred Provider Organizations *	Health Maintenance Organizations *
	Insured Plans < 100 Employees	Insured Plans >100 Employees	Self-insured Plans *		
Prescription drugs	97	97	98	99	89
Medical devices	91	92	98	94	83
Contraceptive Sterilization					
Laparoscopic tubal ligation	86	86	86	86	86
Vasectomy	85	85	86	86	88
Abortion					
Dilation and curettage/suction aspiration	64	66	68	67	70
Dilation and evacuation	66	69	68	67	70
Reversible Contraception					
IUD insertion	23	26	25	25	86
Diaphragm/cervical cap fitting	19	21	21	23	81
Norplant insertion	26	28	30	29	59
Norplant removal	30	32	36	33	58
DMPA (Depo Provera) injection	34	39	32	35	74
Diaphragm device	15	15	16	17	52
IUD device	18	18	20	21	47
Norplant device	23	24	27	27	44
Oral contraceptives	32	33	38	41	84
Counseling and Risk Assessment					
Contraceptive counseling	22	22	16	24	96
Preconception risk assessment	40	43	36	42	90

* Includes plans of all sizes.

Percent of typical plans in which specific service is covered subject to additional restrictions, by type of plan

Service	Conventional Indemnity Plans, by size of group			Preferred Provider Organizations *	Health Maintenance Organizations *
	Insured Plans <100 Employees	Insured Plans >100 Employees	Self- Insured Plans *		
Prescription drugs	NA	NA	NA	NA	NA
Medical devices	NA	NA	NA	NA	NA
Contraceptive Sterilization					
Laparoscopic tubal ligation	4	4	5	4	8
Vasectomy	4	4	5	4	6
Abortion					
Dilation and curettage/suction aspiration	21	23	18	20	20
Dilation and evacuation	18	20	18	19	20
Reversible Contraception					
IUD insertion	0	0	0	0	0
Diaphragm/cervical cap fitting	1	1	0	0	0
Norplant insertion	0	0	0	0	3
Norplant removal	6	4	4	4	7
DMPA (Depo Provera) injection	4	4	5	7	6
Diaphragm device	0	0	0	0	0
IUD device	0	0	0	0	0
Norplant device	0	0	0	0	3
Oral contraceptives	8	8	11	7	2
Counseling and Risk Assessment					
Contraceptive Counseling	1	0	0	0	0
Preconception risk assessment	3	4	2	4	3

* Includes plans of all sizes.

Percent of typical plans in which service is not covered, by type of plan

Services	Conventional Indemnity Plans, by size of group			Preferred Provider Organizations *	Health Maintenance Organizations *
	Insured Plans <100 Employees	Insured Plans >100 Employees	Self-insured Plans *		
Prescription Drugs	3	3	2	1	11
Medical Devices	9	8	2	6	17
Contraceptive Sterilization					
Laparoscopic tubal ligation	10	10	9	10	7
Vasectomy	11	11	9	10	7
Abortion					
Dilation and curettage/suction aspiration	15	11	14	13	10
Dilation and evacuation	16	11	14	14	10
Reversible Contraception					
IUD insertion	77	74	75	75	14
Diaphragm/cervical cap fitting	80	78	79	77	19
Norplant insertion	74	72	70	71	39
Norplant removal	64	64	61	62	35
DMPA (Depo Provera) injection	62	57	63	58	20
Diaphragm device	85	85	84	83	48
IUD device	84	82	80	79	53
Norplant device	77	76	73	73	54
Oral contraceptives	60	58	52	52	14
Counseling and Risk Assessment					
Contraceptive counseling	77	78	84	76	4
Preconception risk assessment	57	53	60	54	7

* Includes plans of all sizes.

METHODOLOGY

The 1993 AGI survey of health insurers had three components: commercial insurance companies, Blue Cross-Blue Shield Plans and Health Maintenance Organizations. The surveys for the commercial companies and Blue Cross-Blue Shield Plans were identical, while the survey for the HMOs included identical questions concerning the coverage of specific reproductive health care services as well as other questions specifically relevant to managed care plans. Each of these survey instruments was developed in conjunction with a panel of experts in the health care and employee benefits fields.

- Commercial insurance companies

The commercial insurance survey was sent to the 100 largest commercial insurance companies in the United States based on the ranking of insurance companies -- according to their net accident and health premiums written -- included in National Underwriters Profiles: 1993 Health Insurers. The name and address of the Chief Executive Officer (CEO) of each insurance company was obtained from Best's Insurance Reports: Life/Health Edition.

Based on data included in the National Underwriters Profiles on the total net accident and health premiums written for all insurers, we calculated the share of the total health insurance market that was covered by the sample of the 100 largest commercial insurers. Together, these insurers surveyed accounted for 97 percent of the total health insurance market.

The 12-page survey instrument was mailed to the CEO of each insurer on October 19, 1993. A second mailing was sent on November 12, and telephone follow-up both to obtain additional responses and clarify issues arising from survey responses continued through December 1993.

Insurers were given the following instructions about completing the questionnaire: "Please answer the questions pertaining to your policy/contract written for groups to cover employees and their dependents in 1993. These questions do not apply to coverage written for persons not part of a group or to coverage supplementing Medicare benefits." For purposes of the survey, the term "typical" was defined as "that which represents the coverage written for most of the lives covered under each policy type." The survey was divided into five parts, each on one type of policy/contract, essentially repeating a single set of questions for each type of policy/contract:

- insured indemnity health insurance policies/contracts for groups with fewer than 100 employees (with a special sub-section concerning policies for groups with 15 or fewer employees);

- insured indemnity health insurance policies/contracts written for groups with 100 or more employees;

- self-insured indemnity policies/contracts administered under Administrative Services Only agreements;

- Preferred Provider Organizations (insured and self-insured); and

- Point of Service networks (insured and self-insured).

Of the 100 surveys mailed, 45 insurers participated in the study, 23 insurers indicated that the survey was not applicable because they did not provide group health insurance coverage and 32 did not participate in the project. (The "not-applicable" firms generally did not write group health insurance policies, with most offering only either non-group coverage or Medicare supplement policies.) The most frequently given reason among nonrespondents were the length of the questionnaire and the level of detail required. As a result, 58 percent of the firms for whom the survey is applicable responded. These responding insurers account for 68 percent of the applicable health insurance market, calculated based on net premiums written. Eight of the 10 largest commercial insurance companies responded.

Not all participating insurers wrote all five types of coverage about which they were questioned in the survey. All data presented concern only those insurers that write each type of plan and responded concerning the specific service.

- Blue Cross-Blue Shield Plans

The survey was sent to all 73 Blue Cross-Blue Shield Plans in the United States, based on the listing of all such Plans included in the Blue Cross-Blue Shield Association Winter 1993 Directory. The survey was sent to the CEO of each Plan on October 19, with a second mailing sent November 8. Telephone follow-up continued through December 1993.

The survey instrument was identical to that mailed to commercial insurance companies.

A total of 38 Plans responded to the survey. Thirty-four Plans did not participate, and one Plan indicated that the survey was not applicable since it is an association office that does not actually write insurance coverage. As a result, the response rate is 53 percent of the 72 applicable plans.

- Health Maintenance Organizations

The sample of HMOs was constructed using the 1993 National Directory of HMOs published by the Group Health Association of America. This directory lists the 546 HMOs in operation as of December 1992. Using the data included in the directory, a sample was constructed to include:

- All 106 HMOs with 100,000 or more enrollees. (These 106 HMOs represent approximately 20 percent of all HMOs and account for 68 percent of all HMO enrollees nationwide.)

- A sample of 107 of the smaller HMOs. To obtain this sample, the remaining 440 smaller HMOs were stratified according to enrollment size (HMOs with less than 20,000 enrollees and HMOs with 20,000 to 99,000 enrollees) and region of the country (Northeast, Central, South and West),. We included 23 percent of these 440 HMOs (107 HMOs) by selecting every fourth HMO within regions and enrollment size categories.

Overall, the 213 HMOs included in the sample account for 32.4 million enrollees, 76 percent of all HMO enrollees in 1992.

The HMO survey was mailed on October 25, with a second mailing November 12.

Overall, 106 of the 213 HMOs sampled responded with completed surveys, a response rate of 50 percent. Of HMOs with 100,000 or more enrollees (106 sampled), a total of 61 responded, a response rate of 58 percent. Of HMOs with less than 100,000 enrollees (107 sampled), a total of 45 responded, a response rate of 42 percent.

The HMOs responding to the survey include 17.6 million enrollees, 56 percent of all enrollees covered by the HMOs included in the sample, and 43 percent of all HMO enrollees in 1992.

- Questions asked

Each of the five major sections of the 12-page survey sent to private health insurance companies and Blue Cross-Blue Shield plans contained questions concerning the coverage typically available for a list of 25 specific reproductive health care services, each of which was identified by either CPT-4 codes or codes from the HCFA Common Procedure Coding System, as well as provisions for confidentiality for both spouses and nonspouse dependents. Additional questions concerned the details of the availability of services in Point of Service networks and the coverage of specific services for dependents -- including spouses and nonspouse dependents -- of the insured employee. The sub-section concerning groups with fewer than 15 employees asked about a shorter list of medical services than was include din the full sections.

For each medical service included in the survey, insurers (private health insurance companies and Blue Cross-Blue Shield Plans) and HMOs were asked to indicate whether, in the typical employment-related policy of each of the types included in the survey, it is

"(1) not covered at all;
(2) covered when considered medically necessary or appropriate by the physician; or
(3) covered **only** when additional requirements (i.e., additional written report from the physician providing specific medical justification, prior authorization, etc.) are met?"

Respondents were asked to check one of these three categories. A respondent indicating that a service was covered subject to additional requirements was asked to specify these additional requirements. In general, the additional requirements reported by the insurers and HMOs fell into two categories. The first was that a provider specify the presence of a specified medical indication in order for coverage to be obtained. The second major category of additional requirements was that prior authorization be obtained before a service could be covered.

The 12-page HMO survey instrument continued instructions similar to those in the two other survey instruments concerning benefits provided in the typical plan written to cover employees and their dependents. An identical definition of "typical" was used. The survey defined sub-contracted services" to be in-plan services "delivered by providers not members of the HMO network, but under contract."

The HMO survey also asked identical questions about the coverage of the list of 25 specific reproductive health care services. In addition, the HMO survey asked questions about coverage of out-of-plan services and services to Medicaid recipients.

- Statistical significance

For all three components of this study -- commercial insurance companies, Blue Cross-Blue Shield Plans and Health Maintenance Organizations -- we used a purposive sampling methodology so as to ensure that those companies that provide coverage to the largest number of enrollees were included. The results are expressed as percentages of "plans" (not individuals covered) providing coverage for specific reproductive health services.

Based on a sample of 100 respondent companies, these percentages are accurate within approximately 10 percentage points or less with 95 percent reliability. For example, the 95 percent confidence interval around a percentage value of 50 percent is approximately plus or minus 10 percentage points. (The interval will be slightly narrower for HMOs and slightly wider for private companies and Blue Cross-Blue

Shield Plans combined because of differences in the number of respondent plans). The 95 percent confidence interval around percentage values that are above or below 50 percent become progressively smaller, with the interval around a value of 90 percent for a sample of 100 companies being plus or minus six percentage points.

Tabulations for the coverage of specific services were done combining the information provided by private companies and Blue Cross-Blue Shield Plans. We also did separate tabulations for each, testing whether or not the observed differences were significant. To do this, we computed chi-squared values for the coverage of each service by private companies compared with Blue Cross-Blue Shield Plans, noting cases where the chi-squared values were significant at the .05 level.

Prepared Statement of Betty Dooley

I am Betty Dooley, Executive Director of the Women's Research and Education Institute. I want to thank the members of the Subcommittee on Aging for this opportunity to testify before you today. I commend the Subcommittee for holding this hearing on the important topic of women's health care.

My remarks are taken from a study prepared by the Women's Research and Education Institute, entitled Women's Health Insurance Costs and Experiences. This report was supported by the Kaiser Family Foundation as part of the Kaiser Health Reform Project.

Our report is the first of its kind to examine how much it costs women to look after their reproductive and preventive health care needs. It shows, in a nutshell, that women are particularly vulnerable to high health care costs. This is because women are more likely to use services--especially reproductive and preventive services--and usually have lower incomes than men. Furthermore, the report demonstrates that low-income women, unemployed women, and uninsured women are especially disadvantaged in our present health care system.

This report, prepared by the Women's Research and Education Institute, relied on data from the 1987 National Medical Expenditure Survey. This survey represents the most recent nationally representative data describing the health care use and expenditures of Americans. The analysis of the National Medical Expenditure Survey was conducted by analysts at LEWIN-VHI, a nationally-known consulting firm that regularly conducts analyses for the U.S. Department of Health and Human Services.

Let me take a few minutes to describe some of the principal findings of our report: First of all, this study shows that women of childbearing age are more likely to use health care services than men, largely because of their greater need for preventive and reproductive services. In fact, women age 15 to 44 are twice as likely as men in their age group to use preventive services.

Unfortunately, many women lack adequate coverage for reproductive and preventive services. In many cases, women lack coverage because they are uninsured altogether. In other cases, they lack adequate coverage because their insurance plans exclude reproductive and preventive services or require deductibles and copayments.

The result is that women of childbearing age have higher out-of-pocket costs for health care than men have. In fact, they pay 68 percent more out-of-pocket than men do. When you consider that women's incomes are lower than men's, their health spending looks particularly troublesome: Over twice as many women of childbearing age have out-of-pocket expenditures that exceed 10 percent of their income, compared to men in this age group. Stated differently, women account for 7.4 million of the 10.8 million Americans age 15 to 44 who have out-of-pocket health expenditures in excess of 10 percent of their income. (I refer you to figure one.)

Uninsured and low-income women are especially vulnerable to high out-of-pocket costs: Almost 20 percent of uninsured women have out-of-pocket expenditures that exceed 10 percent of their income. Especially troubling is the fact that one-fourth of poor women of childbearing age have out-of-pocket costs that exceed 10 percent of their income. (I refer you to figure two.)

Our report also underscores how important it is that reproductive services be covered in health care reform. Reproductive services account for a large portion of women's health spending. In fact, expenditures for reproductive services for women of reproductive age total $40.7 billion. This represents one-third of all health expenditures for women in this age group. For an individual woman, out-of-pocket costs for reproductive services can be very steep. One example illustrates this point: Women with a pregnancy-related hospital stay pay nearly $1,100 out-of-pocket for these hospital stays.

This look at women's spending for health care services tells only part of the story. The other part is that high health care costs discourage women from receiving needed care in the first place. The data show that disadvantaged women are less likely to receive needed preventive services. Here are the statistics, as described in figure three.

* The majority of black and Hispanic women don't get preventive services. In fact, almost 60 percent of black and Hispanic women fail to receive preventive services.

* In addition, the majority of uninsured women don't get preventive services. In fact, 60 percent of women without health insurance fail to get preventive services.

* Especially troubling is the finding that the lower a woman's income, the less likely she is to receive preventive services: A full 55 percent of women below the poverty line do not get preventive care.

In summary, I would say that women have a great deal to gain from health care reform. President Clinton's Health Security Act would make some major changes in improving women's access to preventive and reproductive services. Universal insurance coverage would mean that no woman would be left wholly responsible for her health care costs. Health insurance coverage, by itself however, is not enough. Women need a comprehensive benefits package that includes reproductive and preventive services with minimal copayments and adequate subsidies for those who have low incomes.

The President's Health Security Act takes important steps in this regard as well. Family planning, prenatal care, abortion, and contraceptives are all included in the basic benefits package. The financing of the President's plan has more ambiguous implications for women. Low-income persons would receive subsidies for the purchase of health insurance, but the level of those subsidies may be insufficient for low-income women. If women sign on to managed care plans, no copayments would be required for preventive services, but a copayment would be required for reproductive services.

Health care reform must ensure that costs no longer serve as a deterrent to seeking preventive and reproductive services. Providing subsidies for low-income women to enable them to purchase insurance would solve part of the problem. In addition, copayments should be eliminated for the preventive and reproductive services that women require. Only then will health care reform eliminate the financial barriers that discourage women from receiving the care they need.

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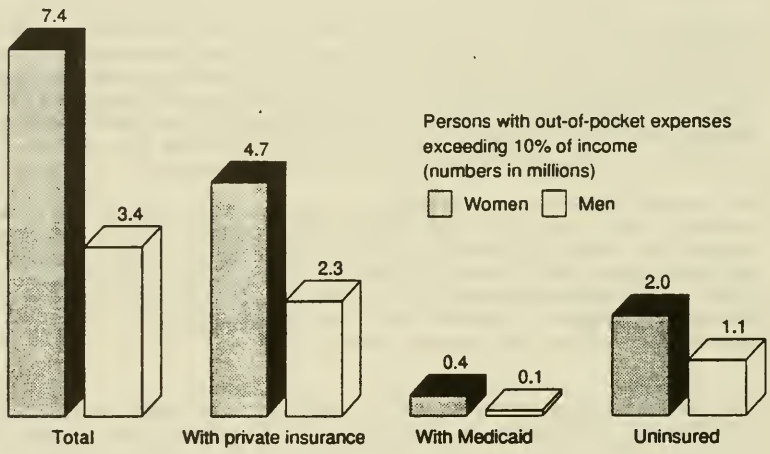
*Figure 1 · Persons age 15 to 44 with out-of-pocket health expenditures that exceed 10 percent of income, by type of insurance coverage.**

MORE THAN TWICE AS MANY WOMEN AS MEN AGE 15 TO 44 HAVE OUT-OF-POCKET HEALTH EXPENDITURES THAT EXCEED 10 PERCENT OF THEIR INCOME.

- ***Women account for 7.4 million (69 percent) of the 10.8 million Americans age 15 to 44 who have out-of-pocket health expenditures of more than 10 percent of their income.***

- ***Almost 5 million privately insured women age 15 to 44 have out-of-pocket expenditures of more than 10 percent of their income.***



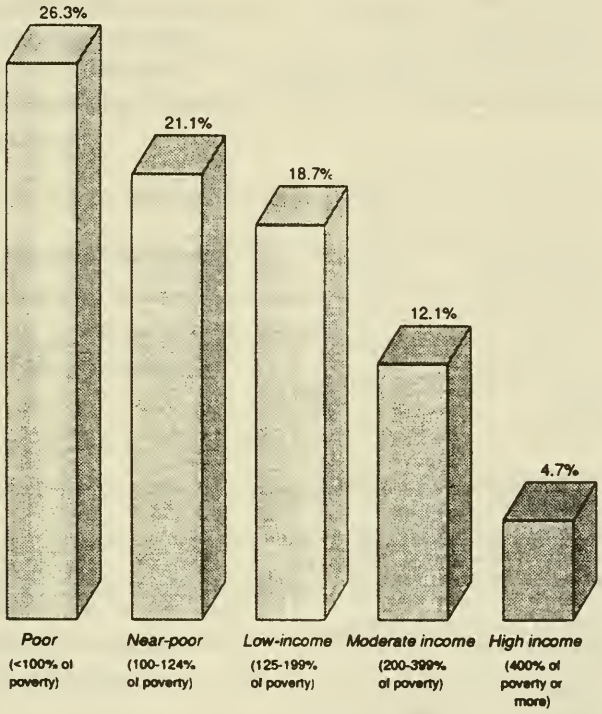
* Out-of-pocket expenditures as a percent of income are calculated by dividing an individual's out-of-pocket expenditures for health care services during the year by an individual's share of family income. An individual's share of family income was defined as total family income divided by the number of persons in the family.

Source: Tabulations of data from the 1987 National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women's Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels. The project is funded by the Kaiser Family Foundation, as part of the Kaiser Health Reform Project.

*Figure 2 · Proportion of women age 15 to 44 with out-of-pocket health expenditures that exceed 10 percent of income, by income level.**

OUT-OF-POCKET HEALTH EXPENDITURES ARE MOST BURDENSOME FOR THE POOREST WOMEN.

● ***More than one-fourth of poor women of childbearing age have out-of-pocket health expenditures that exceed 10 percent of their income.***



* Out-of-pocket expenditures as a percent of income are calculated by dividing an individual's out-of-pocket expenditures for health care services during the year by an individual's share of family income. An individual's share of family income was defined as total family income divided by the number of persons in the family.

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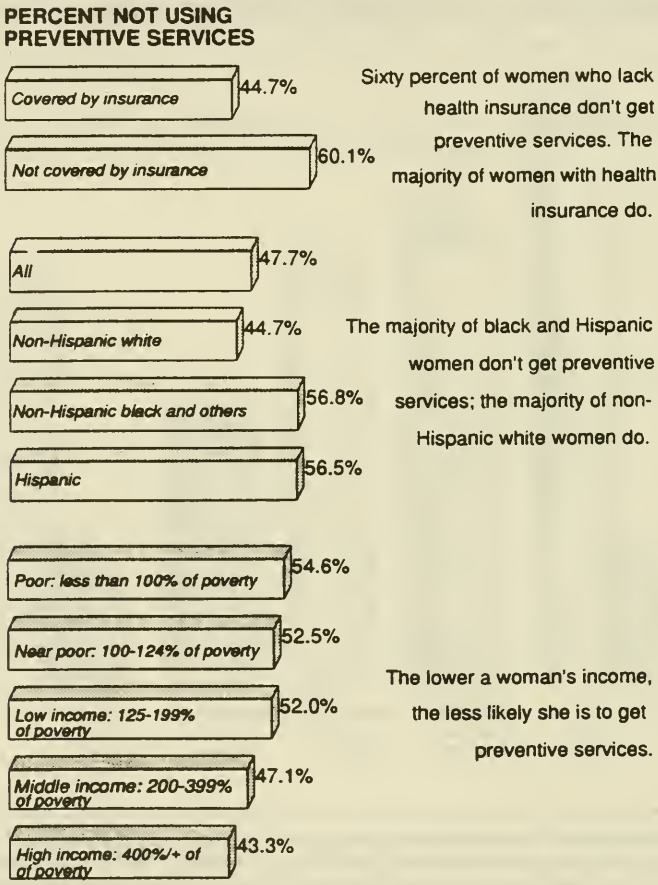
Figure 3 · *Percent of women age 15 to 44 who do not use preventive services, by race/ethnicity, insurance coverage, and income level.*

LACK OF HEALTH INSURANCE IS LIKELY TO MEAN LACK OF PREVENTIVE CARE FOR WOMEN AGE 15 TO 44. BEING OF COLOR AND/OR HAVING A LOW INCOME ALSO REDUCE WOMEN'S USE OF PREVENTIVE CARE.



Source: Tabulations of data from the 1987 National Medical Expenditure Survey (NMES) prepared by Lewin-VHI for the Women's Research and Education Institute (WREI). Expenditure and population data have been updated to 1993 levels. The project is funded by the Kaiser Family Foundation, as part of the Kaiser Health Reform Project.

Prepared Statement of Luella Klein

Mr. Chairman and Madam Chairwoman, Members of the Subcommittee, I am Luella Klein, MD, a professor of obstetrics and gynecology at Emory University School of Medicine and a practicing obstetrician-gynecologist at the Emory University Clinic. On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 34,000 physicians dedicated to improving women's health care, I appreciate the opportunity to testify on the importance of a well-rounded benefit package to ensure that the health of our nation's women is not neglected during reform of our health system.

As a primary care physician, I see first-hand the effects lack of access to health care has on the lives of women. One of the most disturbing experiences is to treat a woman suffering from a devastating or debilitating health condition and know that if I had seen her sooner, I could have prevented or, at least, reduced her suffering.

I am fortunate to have had some involvement in the process of developing President Clinton's health care reform plan. As a member of the Health Professions Review Working Group, my understanding of the objectives and the provisions of President Clinton's Health Security Act, S 1757, was significantly broadened. Certainly, the President and First Lady should be commended for their leadership in bringing health care reform to the forefront of the nation's political agenda -- without their perseverance, I doubt we would be at the brink of finally addressing the ills of our health care system.

While the benefits outlined in the Health Security Act need to be improved in some areas, they generally are a good first step in ensuring that the women in this country are guaranteed access to health care on a regular basis. Like the President, ACOG supports guaranteed private insurance, achieved through an employer mandate, improved coverage of preventive health services (such as maternity care and clinical services to detect and treat cervical and breast cancer), and more primary care for more Americans, achieved by including obstetrician-gynecologists in the definition of primary care physicians in the Health

Security Act. The College agrees with the President that the federal government should take the lead on medical malpractice reform, and was encouraged to see that the Health Security Act included some good first, albeit limited, steps toward achieving this goal.

Today, I will focus on the broad range of vital services for women that should be included in any health system reform legislative package. ACOG believes pregnancy-related, clinical preventive (such as Pap smears, pelvic examinations, and mammograms), and family planning services should be covered according to accepted scientific and medical guidelines. ACOG's own proposal for universal access to pregnancy-related services, entitled *U.S. MaternaCare*, addresses what services, at the very least, should be provided to pregnant women. Furthermore, the College has published numerous documents regarding the performance frequency of Pap smears, pelvic examinations, and mammograms.

It is with regret that I must say that the "Clinical Preventive Services" section is one about which ACOG is most disappointed in the Health Security Act. While the Health Security Act does guarantee coverage for certain preventive health care benefits for women under its schedule of clinical preventive services (S 1757, Title 1, $ 1114), many scientific organizations are disturbed that these services are not covered frequently enough. (A list of the covered preventive services by age group is attached.) The Health Security Act's periodicity schedule is incompatible with ACOG's and many other groups' scientific guidelines for the frequency that women should receive Pap smears, pelvic examinations, and mammograms.

CLINICAL PREVENTIVE SERVICES

Coverage for Pap Smears

In 1988, a consensus recommendation was developed by ACOG, the American Cancer Society, the National Cancer Institute, the American Medical Association, the American Nurses' Association, the American Academy of Family Physicians, and the American Medical Women's Association. These seven organizations suggested that all women who are or have been sexually active or who have reached age 18 should have an annual Pap smear and pelvic examination. It was further recommended that after a woman had three

or more consecutive, satisfactory, normal annual examinations, the Pap smear could be performed less frequently, but only at the discretion of her physician.

However, the recommendation specifies annual Pap smears for women who are at risk for sexually transmissible diseases (STDs), including particularly the human immunodeficiency virus (HIV) or the human papillomavirus (HPV), have multiple sexual partners (or if their partner has multiple sexual partners), or smoke cigarettes. These factors all increase the chances that a woman will develop cervical cancer and necessitate closer monitoring of her health status with an annual Pap smear.

How do our guidelines compare to what is contained in the Health Security Act? Once the clinical preventive services schedule is carefully read and analyzed, it appears that the women of this country may receive less health care than what most have been getting under the current system. While ACOG's guidelines remain constant for all women regardless of age, the Health Security Act breaks women into age categories and provides a different schedule for Pap smears and pelvic examinations. The specific inadequacies and problems posed by the coverage of Pap smears, based upon the age ranges contained in the Health Security Act, are discussed in the attached Appendix.

To summarize our concerns, the Health Security Act's periodicity schedule for Pap smears is not consistent with accepted medical and scientific guidelines. Although exceptions are included to allow women more frequent covered Pap smears, ie: if at risk for "fertility related infectious illnesses" (our concerns with this language are discussed later), or if an abnormal smear is obtained, the legislative language does not address coverage for more frequent screening if the physician feels a woman's lifestyle, risk (such as family history), or health condition warrants it. Nor does it include all of the factors that ACOG believes require annual screening.

The bill also fails to address the situation where more frequent Pap smears are clinically indicated. For example, if a woman receives an abnormal smear that requires evaluation

at more frequent intervals to ensure that the abnormal cells did not evolve into cervical intraepithelial neoplasia (CIN) (dysplasia or carcinoma in situ (CIS)) or invasive cancer, scientific and medical guidelines indicate that Pap smears should be performed at 3- to 4-month intervals for approximately 1 year for preinvasive lesions to evaluate the woman's condition, and annually thereafter. If the lesion is invasive or one has been previously treated, a woman should receive a Pap smear every 3 to 4 months for approximately 2 years, and then every 6 months thereafter.

Although Pap smears have reduced deaths from cervical cancer, the rates for its precursors are on the rise. ACOG strongly urges that all women, regardless of age, are covered for an annual Pap smear without a copayment or deductible. The point of providing preventive services without copayments or deductibles is to encourage people to catch health problems before they become serious. In our view, the goal is to encourage women to get Pap smears at intervals appropriate to their risks for developing cancer. To use copayments and deductibles to discourage them part of the time makes no sense. In addition, we believe it will be very confusing to women if they sometimes have to pay for a Pap smear and sometimes not. The confusion will be further compounded by the government appearing to have one schedule and their doctor another. For the general public to benefit from a health message, it must be clear and consistent.

Although we are heartened by the Administration's statements that "women who are at high risk for cervical cancer or other related conditions will be eligible to receive more frequent Pap smears," we do not find legislative language that reassures us. Since a specific schedule appears in the Health Security Act, it cannot be assumed that the limitations contained within it do not apply to women who have risk factors or specific histories that would warrant more frequent screening. The Health Security Act also states that the comprehensive benefit package does not include coverage for items or services if they are "not medically necessary or appropriate" (S 1757, Title I, Subtitle B, § 1141) -- the very language used by insurers to exclude coverage for preventive services. Furthermore, the National Health Board has legislative authority to decide whether an item or service is

medically necessary or appropriate. These ambiguities need to be resolved in the final reform package because, if history is any teacher, I can guarantee you a literal interpretation of this bill and the services it does, and does not, cover.

The Administration is to be commended for its good intentions with the clinical preventive services section, but their intentions will be meaningless if they are not backed up by specific legislative language. We strongly urge that annual Pap smears, if recommended by a woman's physician, be covered in the final health reform bill. We also urge that it be made clear that more frequent Pap smears can be covered when a woman's condition demands more frequent screening. This language is very clear, thus ensuring that none of the problems arise, detailed in the Appendix, from various interpretations of the current legislative language.

Coverage for Pelvic Examinations

According to S 1757, coverage for pelvic examinations mirrors the coverage for Pap smears for each age group. ACOG does not view Pap smears and pelvic examinations as a "package deal." The College's scientific guidelines urge that women have a pelvic examination annually, irrespective of whether or not they need a yearly Pap smear. We urge that the legislative language be changed to cover all women for a yearly pelvic examination. Pelvic examinations are important because the physician can use it to detect cysts, tumors or other abnormalities. Since no fully competent method of mass screening to detect ovarian cancer has been developed, careful pelvic examination remains the mainstream screening method to date. Furthermore, the physician can also detect the position, size, and contour of the uterus and ovaries during the pelvic examination. The information gleaned from this examination helps the physician evaluate potential fertility problems, abnormal pain, menopause-related problems, and other diseases, such as endometriosis.

Counseling is also a major component accompanying an annual pelvic examination. A woman may change sexual partners, get married, or get divorced -- all actions that affect the counseling I would share with her. As the sole physician for many of my patients, I have

a responsibility to provide them with preventive health care services, including clinical breast examinations, health education, screening for hypertension, STDs, and counseling about health behaviors, such as diet and smoking. Identification of health-related problems, such as depression or domestic violence, also occurs during an exam. Experience teaches me that my counseling will not be effective if I can only talk to my patients every three years.

Coverage for Mammograms

In 1993, it was projected that 183,000 women in the United States would develop breast cancer, and over a third would die from the disease. One in nine U.S. women will develop breast cancer during her lifetime. Moreover, breast cancer is the second-most common cause of death from cancer in women despite the fact that breast cancer screening is the most utilized of all cancer screening procedures. Women between the ages of 35 and 50 are at the most significant risk, since breast cancer is the leading cause of death for women in this age group.

Early detection and treatment of breast cancer greatly reduces morbidity and mortality. Until we learn to prevent breast cancer, mammography screening is the only method available to detect the cancer at the earliest stages when it is most likely to be cured. With neither efficacy or safety in doubt, mammograms are only effective in the screening of cancer when appropriate screening intervals are utilized.

ACOG recommends mammograms every 1 to 2 years for women aged 40 to 50, and annually for women over 50 years of age. These recommendations are based upon the most optimal risk-benefit ratio for cancer screening. Studies to date have not provided conclusive evidence to warrant changes in these guidelines. The American Cancer Society, the American Medical Association, and the American Medical Women's Association all agree these recommendations be followed, despite changes in other groups' policies. Any change in established guidelines must be based on the underlying science, not on "the bottom line." To decrease screening in the absence of conclusive data and in the name of cost containment is to promote a diminished standard of care for American women.

Under the Health Security Act, mammograms are covered only for women age 50 and over every two years. While diagnostic mammograms for symptomatic women are presumably covered under the diagnostic X-ray provision at any age, annual screening mammograms for asymptomatic women over age 50 are not covered under any circumstances, even if they have had breast cancer before or have a family history of the disease. Furthermore, screening mammograms are not covered under any circumstances for asymptomatic women under the age of 50. This includes women who have previously had breast cancer or have a family history of it.

Although screening women aged 40 to 49 may not be as cost-effective as screening women over age 50, one-quarter of all deaths from breast cancer occur to women diagnosed in their 40s. In addition, cost considerations do not justify the estimated 15% of breast cancers that would be missed if screening intervals for women over 50 were changed to biennially. Given the aforementioned risks, I believe that the Health Security Act's coverage of mammograms for women is woefully inadequate. We urge that the Health Security Act's periodicity schedule for mammograms be changed to mirror the guidelines embraced by ACOG, the American Medical Association, American Medical Women's Association, and the American Cancer Society.

<u>Clinician Visits</u>

Although much of my testimony on the clinical preventive services section focuses on the inadequacies posed by the coverage of screening tests, I am also concerned about the coverage of the clinician visits. Primary care physicians, like myself, need to see patients annually. Depending upon the age range, the Health Security Act covers clinician visits at the same interval the Pap smear and pelvic examination are administered (as long as the woman has a normal Pap smear history). Only at age 65 and over will a woman be covered for an annual clinician visit.

As I previously mentioned during the discussion of pelvic examinations, counseling is an important part of an annual physician visit. If there is a three-year period between visits (provided the woman has had normal Pap smears), many major changes in her life can

occur. I truly believe that if we are going to improve the health of women in this country, we must not simply allow, but encourage them to have annual visits. Under the Health Security Act, patients who have seen me once a year for the past twenty years will only be allowed to see me six times in the next twenty years if they have normal Pap smears. I believe that the health of many of my patients will be drastically affected by such limited access to preventive care.

Other Problems with the Clinical Preventive Services Section

ACOG and other medical organizations are concerned about the use of the term "fertility related infectious illnesses," which is one of the caveats under the Health Security Act that would allow a woman to be covered on an annual basis for a Pap smear and pelvic examination. "Fertility related infectious illness" is not a medical term generally used by health care providers. Assuming the best, it is being used as a euphemism for the more widely used term, STDs. Practical realities would dictate that the more common phrase be used, especially since most of the lay population and the health care community knows what it means. I daresay that if you asked people in this hearing room, very few of them would know what a "fertility related infectious illness" was.

Moreover, we are concerned that the term is not synonymous with sexually transmissible disease. Taking this literally, a woman who has reached menopause, had a hysterectomy, or had a tubal ligation would not be "fertile," so annual Pap smears and pelvic examinations would not be covered since she is not at risk for a "fertility related infectious illness." Since the new term is not defined, it can also be assumed that annual Pap smears for STDs which do not affect fertility, such as HPV, will not be covered as an annual screening.

We recommend that this term be changed because it only leads to confusion. It is not based upon a medical or scientific phrase. And it is not a phrase that is universally recognized by the average American. This country is finally on the brink of having most of its population know what an "STD" is, so it seems incomprehensible that a bill would try to reinvent the wheel, as it were.

An even more basic problem is that there seems to be a mistaken view that the number of one's current sexual partners is the risk factor for cervical cancer. The real risk is based upon the total number of partners one has in her life. Of course, the number of sexual partners her partners have had is also part of the equation.

Coverage for Pregnancy-related Services

As advocates for women's health, ACOG is pleased that the Health Security Act specifically covers family planning and pregnancy-related services. Without a definition of what is covered under pregnancy-related services, we cannot be specific in our comments. Nonetheless, ACOG is operating under the assumption that standard prenatal and postnatal services are covered, and is heartened to see that these services are covered without a copayment. We also believe that guaranteed private insurance must also include abortion care, which is included as a minimum benefit in our own *U.S. MaternaCare*.

Millions of pregnant women are lost in the coverage gaps of the current health care system, leaving their health status extremely vulnerable. It is estimated that of the 37 million Americans under the age of 65 who are uninsured, 9 million are women of childbearing age. Pregnant women who lack health insurance are less likely to obtain adequate prenatal care, and are more likely to face a poor pregnancy outcome than are women with health insurance. Effective prenatal care can reduce maternal and infant mortality, and the rate of low-birthweight babies born in this country. Low-birthweight newborns tend to have longer hospital stays upon birth, have increased mortality risks, and are susceptible to a wide range of illnesses, including neurodevelopmental handicaps and congenital anomalies.

While prenatal care is considered a preventive service, the actual delivery of the infant is subject to a copayment and deductible under the Health Security Act, which the College finds puzzling. Effective maternity care has historically been a continuum -- artificial barriers and distinctions between prenatal, delivery, and postnatal services will only lead to women viewing them as options during their pregnancy and not a vital package that assures the health of their infants and themselves.

For those considering a pregnancy, coverage should include a preconceptional health evaluation. This provision is extremely important because it provides an opportunity for counseling about important lifestyle and preventive issues to ensure a positive pregnancy outcome in the future. Studies indicate that women who maintain healthy lifestyles prior to conception typically give birth to healthier babies. Preconception care is also important to ameliorate the impact of any preexisting disease, such as diabetes, on pregnancy outcome.

ACOG's proposal, *U.S. MaternaCare*, covers all pregnant women, regardless of citizenship or residency, and includes the following: a prepregnancy evaluation; pregnancy diagnosis; prenatal care, including fetal evaluation, health and childbirth education, and treatment for new or preexisting conditions that affect the pregnancy; nutritional counseling; abortion services (if desired); substance abuse counseling and treatment; prescription drugs; labor and delivery in a facility appropriate for the anticipated obstetric and neonatal risk posed by the individual patient, and; support services, such as case management, home visiting and transportation. It also covers infants for their first year.

We are disturbed that the Health Security Act covers only American citizens and legal residents -- according to the bill, undocumented aliens are not covered, but may obtain services if it is an emergency or through individual state-run programs. The consequences of lack of health insurance are no less devastating for undocumented aliens, and lack of access to maternity care is particularly troubling. The children of undocumented aliens are American citizens who deserve a healthy start in life, and I hope Congress will address this issue.

<u>Coverage for Family Planning Services</u>

ACOG believes that family planning services, including sterilization, should be covered without a copayment under any health system reform proposal. Family planning services are fundamental to preventive health care for women since the ability to control the spacing and timing of pregnancy directly relates to the health and well-being of women and their

infants. Family planning services are low-cost and cost-effective, and include counseling on contraceptive techniques, prescribing or providing contraceptive supplies and/or insertion of contraceptive devices, and the screening and treatment of STDs.

The Health Security Act covers family planning services. However, the covered family planning services under the Health Security Act are not defined as a preventive service and therefore are subject to cost-sharing. It is hard for us to fathom a definition of preventive services that would not include family planning services. ACOG believes that family planning services should be classified as a preventive service, much like prenatal care, so that lack of money does not prevent women from planning their pregnancies.

It should be noted that over-the-counter contraceptive devices, such as condoms, sponges, and spermicides, are not covered under the President's plan. With infection from AIDS, HPV, and other STDs running rampant, it seems that out of concern for public health the that Administration would want to ensure that all forms of contraception be available and covered, without copayment, under the Health Security Act. We urge that language be included in the final bill to include these other forms of birth control.

Conclusion

In closing, I would like to thank you for holding this hearing. Certainly, the President's guaranteed national benefits package will have a major impact on the women of this country. We commend the President for taking this major step forward in improving women's health. With the refinements we have suggested, we believe women's health will be improved. As Congress deliberates on health care reform, I implore you to take into consideration the health concerns of women rather than the economic benefits derived by limited access to appropriate care. Please do not let financial concerns overshadow the very real lives and health of the women of this country – they, as well as future generations, will be gravely affected if their access to providers and medical care is curtailed. We taxpayers pay for a thorough annual physical examination for our President and his family; American women should receive no less.

[Additional material is retained in the files of the committee.]

Statement of the National Right To Life Committee, Inc.

What does the debate over national health care legislation have to do with abortion?

Regrettably, President Clinton is allowing pro-abortion advocacy groups to attach their extreme agenda to health care legislation, in order to force abortion on demand into virtually every nook and cranny of the American health care system-- and to compel every American to pay the bill.

As part of his health care bill, President Clinton has proposed making paid abortion on demand a federal entitlement. If the Clinton plan passes, taxpayers would pay for virtually every abortion performed in the United States (except those performed on undocumented aliens). As discussed further below, that would include abortions performed simply as a method of birth control (at least 43% of abortions are repeat abortions, based on data published by the Alan Guttmacher Institute), or for other reasons opposed by the overwhelming majority of Americans, such as selecting the sex of a child allowed to be born. It would also include abortions performed during the late months of pregnancy.

The Clinton bill, called the "Health Security Act" (HSA) (HR 3600, S. 1757) defines abortion as a part of a government-mandated "comprehensive benefit package." That would have the effect of making it impossible to market a health insurance plan that did *not* provide abortion on demand. This means that every working American would be forced to pay for unrestricted abortion-- through taxes, and through payroll deductions to pay the mandatory "premiums" required under the Clinton bill.

The Clinton bill requires every health policy to pay for "family planning services and services for pregnant women," which has the effect of requiring payments for abortion on the same basis as contraception or pre-natal care. This amounts to a federal requirement that abortion be provided and paid for as if it were simply a routine method of birth control. Yet a November, 1992 Wirthlin poll found that 84% of Americans oppose abortion being "allowed" as a method of birth control.

(A survey of women obtaining abortions, published by the Alan Guttmacher Institute, found that only 3% of the women surveyed said a "health" problem was the most important reason for their abortion, and only 7% said that "health" influenced their decision in any way. "Why Do Women Have Abortions?," 1988.)

Many millions of Americans recognize abortion not as a "health benefit," but as an act that deliberately extinguishes the life of a helpless member of the human family. These Americans should not be forced to purchase abortion insurance or to otherwise pay for abortions.

Pro-life groups want abortion excluded from any government-defined basic benefits package. There are many other medical or quasi-medical services that are not included in the Clinton bill's guaranteed package, such as non-emergency dental and vision care for adults, hearing aids, and custodial care (except certain hospice care). Excluding abortion from the federally mandated benefits package would leave citizens or employers free to purchase supplemental insurance to cover abortions, if they so desire. (See S. 1757, pages 15-16.)

Would the Clinton health care proposal significantly change abortion policy in the United States?

Yes. Knowledgeable persons on both sides of the abortion issue recognize that the President's proposal would be a dramatic expansion in government promotion of abortion.

Pro-abortion advocacy groups want to "piggyback" their ideological agenda on health care legislation in order to force all Americans to participate in abortion-- including the many millions who recognize that each abortion takes an innocent human life.

Pamela Maraldo, president of the Planned Parenthood Federation of America (PPFA), which operates the nation's largest chain of abortion clinics, said that her organization is determined to ensure "that all reproductive health care -- including abortion services -- are woven into the mainstream of health care delivery in America." This would be accomplished, Maraldo indicated, by including abortion in a federal health benefits package--which she said would be "the 'defining moment' for reproductive rights in America... a watershed event just as significant, just as vital, as the Supreme Court's decision on *Roe v. Wade*." (July 12, 1993 speech)

Wanda Franz, president of the National Right to Life Committee (NRLC), said, "The Clinton plan would use the power of federal law to force Americans to pay for abortion as a routine method of birth control, and would greatly increase the number of abortions."

Kelli Conlin, Executive Director of the National Abortion Rights Action League (NARAL) New York affiliate, said on July 1, 1993, on the Cable News Network:

> Federal funding is critical because it [abortion] is a health care option for women. Just as you would have your pancreas being operated on covered, just as you would have many other kinds of medical procedures, we see abortion as a medical procedure.... The big battle is national health care reform. That's something that will be a quantum leap for women all across every economic spectrum in this country.

Despite this shared recognition of the far-reaching implications of the Clinton plan, President Clinton and First Lady Hillary Rodham Clinton have made strenuous efforts to downplay the pro-abortion aspects of the proposal. For example, in a September 23, 1993 interview on Cable News Network, Hillary Clinton made this statement:

> We are not increasing the availability or decreasing the availability of abortion. We are really trying to strike a balance so that we provide what is available now.

As the information in this factsheet demonstrates, this statement by Hillary Rodham Clinton was blatantly misleading.

What *is* the status quo on abortion in the United States?

Currently, abortion is legal in every state, but it appears that the vast majority of abortions are actually provided and paid for by private parties, not by any level of government.

Abortion is currently legal in every state because this is required by past U.S. Supreme Court decisions (especially *Roe v. Wade*, 1973). The most recent pertinent Supreme Court ruling (*Casey v. Planned Parenthood*, 1992) allows states to place only very modest limitations on abortion, such as a 24-hour waiting period. However, the Court has prohibited any state law or policy that would place a "substantial obstacle in the path of a woman seeking an abortion" (the so-called "undue burden" test).

Currently, it appears that the great majority of abortions are paid for by private individuals with their personal funds. Some group health insurance policies pay for abortion on demand, but many others do not; in some states, such coverage is very uncommon. For example:

> ***Omaha World-Herald*, September 28, 1993:** "'Most plans do not cover elective abortions...' said Reisha Johnson, administrator of Women's Medical Center of Nebraska, one of the state's three abortion clinics. 'If we can get insurance plans to cover it, that would be a real boon.'"

> *Kansas City Star*, October 31, 1993: "Patty Brous, executive director of Planned Parenthood of Greater Kansas City, said... 'It's rare to have a patient who comes to us with abortion coverage in an insurance plan, but it does happen occasionally.' Other clinics estimated about 10 to 20 percent of their patients are able to pay for abortions with the help of insurance."

> *St. Louis Post-Dispatch*, September 24, 1993: "The insurers that cover abortion are few and far between," said B.J. Isaacson-Jones [president of Reproductive Health Services, Missouri's largest abortion clinic].

The Supreme Court has also ruled that the U.S. Constitution does *not* require states to provide funding or facilities for abortion. In upholding the constitutionality of the federal Hyde Amendment, which denies federal Medicaid funds for nearly all abortions, the Court ruled:

> Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life. [*Harris v. McRae*, 448 U.S. 297, 325 (1980)]

The Supreme Court has also held that *Roe v. Wade* docs *not* prevent the government from making

> a value judgment favoring childbirth over abortion, and... implement[ing] that judgment by the allocation of public funds. [*Maher v. Roe*, 432 U.S., at 474 (1977)]

How would the Clinton proposal change the current situation?

Currently, where an insurance plan does include abortion, it is a decision between the insurer and the purchaser of insurance-- not the result of any government mandate. Indeed, abortion coverage is the exception rather than the rule even in health plans operated directly by the government. For example, with the federal-state Medicaid program, which provides medical benefits for about nine million poor women and their dependents, federal funds are available for abortion only in cases of rape, incest, or to save the life of the mother. About three-fourths of the states likewise prohibit the use of state funds for abortion, except in rare circumstances. The Department of Defense is also barred from paying for abortions.

Currently, there are about 1,600,000 abortions performed each year, at a total cost estimated at $742 million. These numbers could be expected to rise sharply under the Clinton proposal, which would have the federal government would <u>guarantee</u> local access to abortion at nominal cost, and force nearly all Americans to pay for it.

How, specifically, would the Clinton proposal mandate universal abortion coverage?

The Clinton plan would force nearly all health insurers and health care providers to aggregate into networks similar in some respects to current Health Maintenance Organizations (HMOs). These networks would be called "health plans."

The bill would not allow health plans to simply market their services to the public. Instead, the proposal would establish new quasi-governmental bodies called "health alliances"-- at least one for each state, with many states broken into smaller regional alliances. With narrow exceptions, all Americans would be required to join the health alliance for their region. (See S. 1757, page 15.) The health alliance would negotiate with various health plans, and would determine which plans would be certified for sale to the public.

In order to be approved, a health plan would be required to provide a a specified "comprehensive benefit package." These benefits are listed in the Clinton proposal. The list does not mention the *word* abortion. However, "family planning services and services for pregnant women" are listed as part of the mandatory benefits package. (See S. 1757, pages 33, 63)

Experts on both sides of the abortion issue say that this language would clearly include abortion. Moreover, President Clinton and First Lady Hillary Rodham Clinton have made statements that acknowledge that abortion is included under "services for pregnant women."

For example, speaking to a sympathetic audience at a luncheon sponsored by *Self* magazine on October 5, 1993, Hillary Clinton offered this characterization of the proposal:

> The benefits package will include pregnancy-related services. And, in each health plan... those decisions concerning abortion will be made by the physician and the woman... Abortion will be considered a pregnancy-related service, and will be available through accountable health plans.

Why does NRLC say that the Clinton bill has a "built-in Freedom of Choice Act"? Would the bill nullify state limitations on abortion, such as parental consent laws and 24-hour waiting periods?

Under the Clinton bill, no state or local government may place limitations on access to a federally guaranteed health benefit-- which is to say, any service included in the bill's "comprehensive benefits package," such as abortion. The bill specifically empowers the National Health Board to issue regulations to insure national "uniformity" of access to all "guaranteed benefits."

> The items and services in the comprehensive benefit package shall not be subject to any duration or scope limitation or any deductible, copayment, or coinsurance amount that is not required or authorized under this Act. [S. 1757, page 34.]
>
> The National Health Board may promulgate such regulations or establish such guidelines as may be necessary to assure uniformity in the application of the comprehensive benefit package across all health plans. [S. 1757, page 92]

Under the Supremacy Clause of the Constitution, federal regulations that are validly based on federal statutory law-- such as the provisions quoted above-- will nullify any conflicting state or local laws.

Thus, the Clinton bill would result in nullification of *any* state law that places a specific limitation on access to abortion. This would include, for example:

-- laws requiring notice to, or consent of, a parent or parents (or authorization by a judge) before an abortion can be performed on a minor.

-- laws requiring a waiting period prior to an abortion, such as the Pennsylvania law requiring a 24-hour waiting period, upheld by the Supreme Court in 1992.

-- "women's right-to-know" laws requiring that women be offered state-prepared informational materials on such subjects as alternatives to abortion or fetal development prior to obtaining an abortion.

-- limitations on third-trimester abortions. About half of the states currently have some such limitations, although many of these are very weak. [See page 20].

-- restrictions on abortions performed solely to determine the sex of a baby to be born. [See page 21.]

-- so-called "doctor-only laws," in effect in 46 states, that prohibit *non-physicians* from performing abortions. [See page 21.]

The government-mandated benefits package described in the Clinton plan covers only "medically necessary or appropriate" services. Would that language limit the number of abortions funded?

Authorities on both sides of the abortion issue agree that, in this context, this language does not constitute a real limitation. With respect to government health programs-- Medicaid, for example-- federal administrators have construed "medically necessary" to apply to any abortion performed by a qualified medical professional, except where Congress says otherwise. For example, the federal Medicaid program was reimbursing states for so-called "medically necessary" abortions at the rate of 300,000 a year by 1976, when Congress put a stop to this practice by enacting the Hyde Amendment (which in effect carved abortion out of the class of "medically necessary" procedures).

Thus, the Clinton bill will require payments for all elective abortions, unless Congress explicitly removes abortion from the benefits package (as Congress has done for Medicaid by enactment of the Hyde Amendment).

Many pro-abortion advocates acknowledge this. For example, William Hamilton, vice-president of the Planned Parenthood Federation of America, told Knight-Ridder Newspapers that "medically necessary" means "anything a doctor and a woman construe to be in her best interest, whether prenatal care or abortion." (*Philadelphia Inquirer*, Sept. 8, 1993) [Further documentation on the scope of this point is available on request from the National Right to Life Committee.]

President Clinton himself said:

> This will guarantee most [sic] plans will cover abortion... **if a doctor and a woman decide that is an appropriate pregnancy-related service, under this plan then it could be provided.**" (*MTV News*, Sept. 21, 1993) [emphasis added] [As explained below, "most plans" really means "all plans."]

It should be noted that several of the alternatives to the Clinton bill, proposed by various Members of Congress, also provide for government-defined "benefits packages" that would include abortion. This is true, for example, of the Cooper-Breaux "managed competition" bill (HR 3222, S. 1579), the McDermott-Wellstone "single-payer" bill (HR 1200, S. 491), and the Chafee-Thomas bill (S. 1770, HR 3704). All of these bills must be amended to exclude abortion from the scope of any such benefits package. [See pages 22-23 of this factsheet for further details.]

Under the Clinton plan, who would pay for abortions?

Under the Clinton plan, anyone who pays taxes would pay for abortion on demand, since the government would pay the costs of health care for persons currently covered by Medicaid or otherwise unable to pay the government-mandated "premiums." In addition, employers and their employees would be compelled by law to pay "premiums" to cover the cost of the mandatory benefits package, including abortion. Thus, the cost of most abortions would be paid by average working Americans, and their employers, through mandatory paycheck deductions. As explained above, contrary to statements made by the President in September, there are <u>no exceptions</u> to the requirement that <u>all</u> health plans include abortion services.

How would the Clinton proposal require use of direct tax revenues (in addition to the mandatory "premiums") to pay for abortion on demand?

The Clinton bill would require government-funded abortion on demand for low-income women-- and on an unprecedented scale. The government would use general tax revenues to pay the cost of health coverage-- including abortion-- for those Americans who are deemed too poor to pay the government-mandated "premiums."

In March of 1993, President Clinton asked Congress to repeal the Hyde Amendment, which prohibits federal funding of abortion under the Medicaid program. However, both houses of Congress have rejected the President's recommendation, voting to continue to prohibit Medicaid funding of abortion, except when the life of the mother is endangered, or in cases of rape or incest. The congressional votes reflect public opinion polls that show substantial majorities of Americans oppose government-funded abortions (see page 14).

However, under the Clinton proposal, women currently covered by Medicaid would be brought under the guaranteed benefits package, with the government paying for their benefits-- including abortion on demand. "The former Medicaid recipients will have their premiums in the [health] alliance subsidized by government," explained Senator Harris Wofford (D-Pa.), a supporter of the Clinton plan.

No state would be permitted to "opt out" of the abortion mandate under the Clinton plan. Leading pro-abortion advocates understand this very well. Asked by a reporter what kind of system she "foresees under the new plan," National Abortion Rights Action League (NARAL) President Kate Michelman responded:

> A system where the availability of family planning, contraception and abortion is federally mandated, that the states cannot opt in or out as they do with Medicaid. (*Newsday*, June 28, 1993)

In addition, the basic package, including abortion, would be extended to some 39 million Americans who currently have no health insurance at all-- even Medicaid. Here too, massive tax subsidies will be required.

Thus, the Clinton bill would effectively nullify both the federal Hyde Amendment, which prohibits most federal funding of abortion, and all state restrictions on tax-funded abortions. (Currently, 37 states provide state funds for abortions only in narrow circumstances, while only 13 states fund abortion on demand. A listing of state abortion funding policies is available on request from the NRLC Legislative Office.)

Has President Clinton acknowledged that his proposal requires federal funding of abortions?

Yes, when pressed on the question. In a September 23 "town hall meeting" in Tampa, broadcast live on ABC, a pro-life nurse told the President, "you are personally and morally involving me in the abortion issue by using my tax money." In replying, the President did not deny that the plan involves tax funding of abortions, but responded, "We are also personally and morally improving preventive and primary health services."

The ABC broadcast also included the following exchange between ABC's Ted Koppel and the President:

> **President Clinton:** What we are trying to do is to stop the two-tiered system to put the Medicaid patients in with the employees of small businesses and hospitals and others to provide for a common private system in which people join plans that provide services, including pregnancy-related services...
>
> **Ted Koppel:** Are tax monies going to be used to support those abortions?
>
> **President Clinton:** The answer is, indirectly they will... Under this system, people on Medicaid would be just like any other person. They'd join a health plan, they'd sign up for certain services. The funds, the public and the private funds, would all be mixed together.
>
> **Ted Koppel:** ... So implicitly, the answer is yes, they will be.
>
> **President Clinton:** They will be able to fund it, that's right.

Under the Clinton proposal, would Americans have the option of purchasing health plans that do *not* pay for abortions?

No. The Clinton proposal would make abortion part of the guaranteed basic benefits package, which means that paying for abortion on demand would be *mandatory* for every health plan and for every American.

Many people are still confused on this point, partly because of misleading public statements made by President Clinton, First Lady Hillary Clinton, and various Administration officials in the fall of 1993-- statements inconsistent with the actual language of the Clinton proposal submitted to Congress on November 20, 1993.

For example, President Clinton described his proposal this way on *MTV News* (September 21, 1993):

> This will guarantee that most [health] plans will cover abortions. Now, there will be religious exemptions, which there are today. Catholic churches or other religious groups that have health plans won't have to cover it. Doctors who have religious problems won't have to do it. But if a doctor and a woman decide that that is an appropriate pregnancy-related service under this plan, then it can be provided.

President Clinton also said several other times during September that his proposal would give people the option of choosing plans that did not include abortions.

However, all of those statements are flatly contradicted by the language of the actual Clinton bill submitted to Congress in November. The bill contains a so-called "conscience clause," which merely permits *an individual doctor* to refuse to perform abortions or *an individual hospital* to refuse to allow abortions on the premises. This provision reads:

> A health professional or a health facility may not be required to provide an item or service in the comprehensive benefit package if the professional or facility objects to doing so on the basis of a religious belief or moral conviction. [See S. 1757, page 95.]

Subsequent to the September statements by President Clinton and Hillary Clinton, quoted above, Administration officials acknowledged that the "conscience clause" applies only to individual persons and hospitals, and does *not* apply to *health plans*. White House health spokesman Kevin Anderson told *American Medical News* (October 25) that

> The conscience clause does not reside with the health plan... The plan cannot prohibit a willing provider from doing abortions.

However, Mr. Anderson engaged in a gross understatement when he merely conceded that under the Clinton bill, a health plan "cannot prohibit" any of its providers from providing abortions. Another Administration spokesperson came a bit closer to the truth in a statement published in the *Baltimore Sun* (September 25, 1993):

> A top official of the Department of Health and Human Services who helped draft Mr. Clinton's reform proposal, Judith Feder, said yesterday... "Unless a [health] plan were made up *solely* of providers who invoked a conscience clause, which would be the exception rather than the rule, plans would cover abortion." [emphasis added]

In truth, however, the actual Clinton bill clearly requires that *every health plan provide abortions-- or it cannot be certified for sale to the public*. Thus, even if a plan's basic network of health care providers consisted *entirely* of doctors and hospitals that refused to perform abortions, *the plan itself would be legally obligated to find some other provider to perform abortions, and to pay for all of the abortions performed.*

The bill would prevent certification (or recertification) of any health plan for sale to the public unless that plan provides all of the federally mandated benefits-- and that includes abortion.

> Each health plan must enter into such agreements with health care providers or have such other arrangements as may be necessary to assure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled with the plan. [S. 1757, page 234.]

> ...[A] participating State shall establish and publish the criteria that are used in the certification of health plans...Such criteria shall be established with respect to...(C) the plan's capacity to deliver the comprehensive benefit package *in the designated service area.* [S. 1757, page 101, emphasis added.]

> A regional alliance is not required under this section to offer a contract with a health plan if...the plan has failed to comply with requirements under prior contracts with the alliance, including failing to offer coverage for all the services in the comprehensive benefit package *in the entire service area of the plan.* [S. 1757, page 132, emphasis added.]

In other words, no health plan (network) can exist under the Clinton system unless it pays *someone* to provide abortion on demand locally throughout "the entire service area of the plan."

There are *no exceptions* to the requirement that all plans provide abortions. As a result, all American employers and their employees would be compelled to purchase abortion coverage. This was underscored in the following exchange between Congressman Dennis Hastert (R-Il.) and DHHS Principal Deputy Assistant Secretary Judith Feder at a public hearing conducted by the Health Subcommittee of the House Energy and Commerce Committee on January 26, 1994:

> **Congressman Hastert:** Is it also correct or incorrect that, under the Clinton bill... [a Catholic hospital] would have to contribute to a health insurance plan for its employees that does cover abortions?

> **Feder:** All employers are expected to make contributions.

Thus, Greg Erlandson-- editor of the Catholic weekly newspaper *Our Sunday Visitor*-- did not exaggerate when he wrote as follows in an essay published in the *Wall Street Journal* (November 26, 1993):

> The federal government may soon try to force Cardinal John O'Connor of New York and his fellow bishops to pay for the abortions of their diocesan employees and their families. In fact, health care reform as proposed by the Clinton administration will require the Church of Jesus Christ of Latter-Day Saints, the Southern Baptist Convention, the National Right to Life Committee and even the Catholic publishing company I work for to do the same for all their employees and families.

> ... the evil genius of the Clinton proposal is that it will co-opt everyone, including those leaders and institutions that have been most outspokenly critical of abortion. By making abortion a requirement of the basic health-benefits package, the Clintons would use the might of federal law to force a host of companies, foundations and organizations to choose between closing their doors for good and subsidizing what they understand to be the destruction of human life. The implications of the Clinton proposal are as far-reaching as the Supreme Court's *Roe v. Wade* decision 20 years ago-- and potentially as disruptive... on a scale that beggars the imagination, the Clinton administration is seeking to ignore the genuine divisions that exist on this issue by institutionalizing abortion as a medical "right." Employers will be coerced into helping to pay for this right because abortion will be mandated as one of the core benefits that every insurer must offer.

All of these requirements would be enforced by a powerful "National Health Board," appointed entirely by President Clinton, which would have sweeping powers to insure that every mandated service-- including abortion-- is available everywhere. [See S. 1757, pages 92, 260]

Moreover, as Hillary Clinton explicitly confirmed in September 29, 1993, testimony before the House Ways and Means Committee, *the mandatory abortion requirement applies to every health alliance.* (This would include Canadian-style "single-payer" alliances in those states that elect to establish them.) Indeed, under the Clinton bill, the National Health Board can *take over* any health alliance that does not enforce the federal law-- including insuring the provision of all mandated benefits.

Do pro-abortion advocacy groups agree that all health plans (networks) must provide abortion under the Clinton plan?

Yes. Kate Michelman, president of the National Abortion Rights Action League (NARAL), said on Sept. 23, 1993:

> We support the plan as it stands right now, because it includes the full range of reproductive health, and abortion.

In an earlier interview, Michelman said:

> There can be no flexibility in the sense that one plan can say yes [to including abortion] and another no. This must be considered as basic health care. (Reuters, September 15, 1993)

The Alan Guttmacher Institute, the research/propaganda arm of the Planned Parenthood Federation of America, included the following statements in a recent analysis of President Clinton's "Health Security Act" (HSA), published in the AGI *Washington Memo*, November 9, 1993:

> Every insurance plan in the nation would be required to cover a "comprehensive benefit package" spelled out in the legislation... HSA unequivocally gives insurance plans the obligation to ensure that the full range of covered benefits is available to all enrollees in the plan: [quoting S. 1757, page 234] "Each health plan must enter into such agreements with health care providers or have such other arrangements as may be necessary to assure the provision of all services covered by the comprehensive benefit package to eligible individuals enrolled with the plan." **As a result of this provision, a plan in which none of the participating physicians is willing to provide abortions, for example, would be obligated to refer women elsewhere for the service, and pay providers for their care.** [emphasis added]
>
> HSA has two additional features designed to ensure that the entire benefit package is made available to all enrollees. Both regional health alliances and states would be able to decertify health plans that fail to make all mandated services available. As a last, fail-safe measure, the National Health Board, which would be established by HSA to oversee the newly created system, is charged with taking the steps necessary to ensure "that the comprehensive benefit package is available on a uniform national basis to all eligible individuals." [See S. 1757, pages 92, 95, 101, 132, 260, etc.]

In testimony before the Health Subcommittee of the House Energy and Commerce Committee on January 26, 1994, PPFA Vice-president Jane Johnson testified that the Clinton bill makes "crucial improvements" in the current health care system, among these, that abortion is "implicitly included in the comprehensive package *that all health plans would be required to offer.*" [emphasis added]

Does the American public favor a federal law making abortion a mandatory benefit in all health insurance plans?

No. Polls by diverse national pollsters show strong public opposition-- among both men and women-- to including abortion in any federal health "benefits package," and strong opposition to other forms of tax-funded abortion as well.

The CBS News / *New York Times* poll twice asked specifically (in March and June, 1993), "Should abortion for women who want it be covered as part of a basic health plan or should it be paid for directly by the women who want it?" The results were:

	MARCH 1993			JUNE 1993		
	Total	Men	Women	Total	Men	Women
Should be covered:	23%	24%	22%	25%	26%	25%
Should NOT be:	72%	72%	72%	66%	66%	65%

In October, 1993, Louis Harris-- generally known as a pollster for liberal activists-- asked, "Do you think that the basic health insurance benefits guaranteed to all Americans should include coverage for abortion or should people have to pay extra to have abortion coverage by their insurance?"

Should be included: 27 percent
Should have to pay extra: 62 percent

A *Washington Post* poll (February, 1994) posed this question: "Now I'm going to mention things that might concern some people but not others about the Clinton health care plan. And for each, please tell me if it's a big concern, a small concern, or not at all a concern of yours... The plan will pay for legal abortions:"

Big concern: 47 percent)
Small concern: 21 percent) 68 percent "concerned"
Not at all concern: 33 percent

The NBC poll (September, 1993) asked, "Should national health care program include coverage for abortions?" The result:

Should not cover 52 percent
Should cover 32 percent

These results are generally consistent with polls on the general issue of tax-funded abortions. For example, an ABC News / *Washington Post* poll (July, 1992) posed this statement: "The federal government should pay for an abortion for any woman who wants it and cannot afford to pay."

Agree: 27 percent
Disagree: 69 percent

Under the Clinton proposal, every health plan would be required to provide abortion on precisely the same basis as contraceptives. Yet, most Americans-- including many who regard themselves as "pro-choice"-- reject the notion that abortion should be treated as just another method of birth control. For example, a November 1992 Wirthlin poll asked, "Do you favor or oppose abortion being *allowed* as a method of birth control?" [emphasis added]

	Total Sample	Men	Women
Favor:	13 percent	17%	9%
Oppose:	84 percent	79%	89%

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Do most Americans already have insurance plans that cover abortion?

The Administration's defense of its abortion proposal relies heavily on the unsubstantiated claim-- repeated again and again by the President, the First Lady, and other Administration officials-- that most private insurance plans already cover abortion. (For example: "It'll be just like it is today in most private plans," the President said on the September 21 MTV interview. "Most private plans absolutely cover it.") This claim-- that most Americans currently have abortion insurance-- originated with pro-abortion advocacy groups. The Clinton Administration simply adopted the claim, without offering any evidence to support it.

In truth, while there is no comprehensive database on abortion coverage, it appears that a *minority* of Americans currently have insurance that covers abortions. The *St. Louis Post-Dispatch* reported on September 24, 1993:

> A spokesman for A. Foster Higgins, Inc., a national employee benefits consultant that surveys 2,500 employers a year, said such coverage was common in health maintenance organizations but *unusual in fee-for-service plans and in employers' self-funded plans. Self-funded plans provide health coverage for 65 percent of American workers.* [emphasis added]

Moreover, during 1993 journalists surveyed insurers and abortion providers in some specific states, often finding little abortion coverage in private plans. The *Post-Dispatch* reported that "such [abortion] coverage appears to be the exception in Missouri and Illinois." B.J. Isaacson-Jones, president of Reproductive Health Services, Missouri's largest abortion clinic, told the *Post-Dispatch* that less than 10 percent of the clinic's clients have insurance for abortions. "The insurers that cover abortion are few and far between," Isaacson-Jones said.

Similar results were reported by the *Omaha World-Herald* (Sept. 28). The *World-Herald* quoted Reisha Johnson, administrator of one of the three abortion clinics in Nebraska, as saying, "Most plans do not cover elective abortion. The only one that does to any extent is Blue Cross/Blue Shield...If we can get insurance to cover it, that would be a real boon."

The *World-Herald* also reported:

> Mutual of Omaha, the nation's largest provider of individual health insurance and one of the largest group health insurance providers, generally does not cover abortions...Individual and group policies that Mutual sells 'specifically exclude elective abortions'..."

In addition, three-quarters of the states generally exclude abortion from their Medicaid programs, as does the federal government.

What evidence have pro-abortion advocates put forward to back up their claims that the great majority of private health plans cover abortion?

They have quoted a couple of so-called "surveys" of health insurers-- each of which involved only a tiny, carefully selected handful of the 2,000 or so health insurers in the United States. For example, a polemical piece by Bettijane Levine of the *Los Angeles Times* (April 22, 1993), sometimes quoted by pro-abortion advocates, relied heavily on interviews with insurance sources in California-- a state in which abortion coverage appears to be much more prevalent than in many other states.

In testimony before the Health Subcommittee of the House Ways and Means Committee on November 17, 1993, Planned Parenthood Federation of America (PPFA) President Pamela J. Maraldo offered no evidence that abortion coverage is prevalent in private insurance plans, but she did misattribute the following statement to Bill Gradison, president of the Health Insurance Association of America, an association of health insurers:

> [Abortion] ought to be treated the way it is today in the plans. It is a matter that is covered under pregnancy-related services and it's a matter of medical judgment-- is it medically necessary and appropriate? And that's the way it ought to be treated in the future.

In a subsequent letter to the subcommittee, Mr. Gradison said:

> The statement Ms. Maraldo quoted was made on the September 27 edition of "Face the Nation" on CBS. It was not made by me, however; it was made by Dick Celeste. CBS initially issued a transcript that erroneously attributed the statement to me. [Mr. Celeste was speaking as the head of the public relations campaign for the Clinton plan.]

Moreover, the Health Insurance Association of America has been critical of many aspects of the Clinton health care proposal, and has taken no position on whether abortion should be included in any national health plan. HIAA's Richard Coorsh told *American Medical News* that there is "no formal survey data" on private abortion coverage.

In fact, the lack of a nationwide database on the issue was acknowledged in a monograph published in early 1993 by the PPFA-affiliated Alan Guttmacher Institute:

> [N]o comprehensive or current data exist on private insurance coverage for reproductive health services... Information on coverage for sterilization and abortion is either sparse, lacking or not contemporary. ("Health Care Reform," by AGI President Jeannie Rosoff, 1993)

However, the AGI monograph went on to argue that any federal health reform legislation should *mandate* abortion coverage in part *precisely because* many insurers currently do not regard abortion as an essential part of health care, and thus do not cover it:

> Moreover, most reproductive health services do not conform precisely to either of these categorizations [i.e., treatments to cure illness and treatments to prevent illness] except if pregnancy, or the desire to avoid pregnancy, is considered a disease or disability. Indeed, the insurance industry has viewed them in the past as "elective" measures. "Elective" treatment, in turn, is variously interpreted as a matter of choice for the physician or patient... In this context, contraception, sterilization, abortion and infertility services are often described as "elective," and, therefore, are excluded from coverage. (*Health Care Reform*, Jeannie I. Rosoff, The Alan Guttmacher Institute, 1993.)

The same point was made in a study released on January 26, 1994, by the Women's Research and Education Institute, a group that *supports* federally mandated abortion coverage. (The study was funded in part by the Kaiser Health Reform Project.) The study reported:

> Unfortunately, *many health plans fail to adequately cover* preventive and *reproductive services*, *leaving them out of the benefits package altogether* or requiring copayments and deductibles... Contraceptive services, *including induced abortions*, *are less well covered by insurance than pregnancy-related and other reproductive services.* ("Women's Health Insurance Costs and Experiences," Jan. 26, 1994, pp. 5, 13, emphasis added.)

If new evidence was produced to back up the claim that "most" private insurance plans cover elective abortion, would it then be accurate to say that the Clinton plan would preserve the status quo?

Certainly not. The abortion insurance that now exists is the result of decisions by insurers and insurance consumers. Whatever the percentage of Americans who currently have broad abortion insurance-- almost surely a minority-- the selling and buying of such insurance is voluntary. If a national health system is created, but abortion is *excluded* from the mandated benefits package, that would not prohibit persons or groups from buying such coverage on the private market, as they do now. [See S. 1757, pages 15-16.]

In contrast, the Clinton plan would make such coverage *mandatory* and universal, compelling all Americans to pay for abortion on demand through mandatory "premiums" and direct taxation.

In a review of abortion insurance policies titled "Whose Status Quo?," issued in September 1993 by the Washington-based Family Research Council, Scott Daniels, Ph.D., Director of the Ethics and Health Care Project for the Council, wrote:

> The surveys which the pro-abortion supporters cite as evidence for their claims only polled ten insurance companies, a small minority of the 2,000-plus insurers and of the diverse types of funding arrangements.... [Moreover,] the true status quo regarding elective abortion coverage is that it is *optional*, and several federal laws have established and continue to uphold its "optional" status.
>
> In considering the President's claims, the Family Research Council decided to conduct an informal telephone survey of all the states' insurance departments to discover whether elective abortion coverage has ever been mandated by the states.... We were able to contact 43 state insurance departments including the District of Columbia regarding their state policies on elective abortion coverage in private health insurance. Our findings contradict President Clinton's claim to the status quo: *None* of the states we contacted mandated the inclusion of elective abortion coverage in private health insurance. The states leave the decision to offer elective abortion coverage to the insurance providers. As we have noted earlier, by no means are insurance policies uniformly providing coverage for elective abortion. At least seven states...have mandates *excluding* elective abortion coverage (to varying degrees) in private health insurance.

Would it be a form of "sex discrimination" to exclude abortion from the mandatory benefits package, while covering "male-specific" procedures such as vasectomies and prostate operations?

Many advocates of the abortion mandate try to subsume abortion under "reproductive health services," in effect equating abortion with contraception. Others seek to equate abortion with routine surgical procedures (see the reference to pancreas operations by NARAL's Kelli Conlin, on page 1), or with male-specific procedures such as vasectomies (Congresswoman Patricia Schroeder).

But only a tiny minority of Americans share these ideological positions on abortion. The overwhelming majority-- including most of those who favor some degree of legal abortion-- recognize that there is a fundamental difference between an abortion and a vasectomy, or a pancreas operation, or a true contraceptive.

This is amply demonstrated by diverse public opinion polls showing strong opposition to inclusion of abortion in a national health plan, or any other form of government promotion of abortion, such as those polls cited on page 14, and by the Wirthlin Poll findings that 84% of Americans oppose abortion being permitted "as a method of birth control."

According to NARAL, it would be impermissible for the government to treat abortion differently from other "reproductive health services" by excluding abortion from a government-mandated benefits package. Yet, in a moment of inadvertent candor, even NARAL President Kate Michelman recognized that abortion <u>is different</u>:

> "We think abortion is a bad thing. No woman wants to have an abortion," said Kate Michelman, president of the National Abortion Rights Action League. [Interview with Jodi Enda, published in the *Philadelphia Inquirer*, December 11, 1993, page 1.]

Since abortion is indeed "a bad thing," Congress should refuse to pass any bill that would force-feed abortion on demand into virtually every corner of the entire health care delivery system. Since abortion is "a bad thing," the federal government should seek to discourage it, rather than mandating abortion services in every community and subsidizing abortion as just another "reproductive health service."

Five days after Kate Michelman's statement appeared in the *Philadelphia Inquirer*, NARAL issued a statement claiming that Ms. Michelman "has never said-- and would never say-- that 'abortion is a bad thing.'" An *Inquirer* editor then privately advised NARAL that Ms. Michelman's remarks had been

tape recorded. Nevertheless, when Helen Alvare of the National Conference of Catholic Bishops quoted the Ms. Michelman statement during a January 26 hearing before the Health Subcommittee of the House Energy and Commerce Committee, Ms. Michelman immediately testified as follows:

> I was going to correct, on the record, something that Ms. Alvare said in her statement, that I said abortion was a bad thing. *The reporter quoted me absolutely incorrectly.* [verbal emphasis in original]

According to a February 7, 1994 story in the *Washington Post*, Ms. Michelman "still refused to admit she had made the comments" when contacted by the *Post*. The *Post* also contacted *Inquirer* reporter Jodi Enda, who commented,

"If she [Michelman] says she was misquoted, she's not telling the truth." Enda noted that Michelman had previously been advised that the interview was recorded on tape.

Would Supreme Court decisions such as *Roe v. Wade* and *Casey v. Planned Parenthood*, or state laws, prevent the federal government from paying for third-trimester abortions?

No. The *Roe v. Wade* and *Casey* decisions do not themselves restrict *any* abortions at all. Rather, these rulings merely *allow* states to place very narrow limits on abortion-- including certain limits on third-trimester abortions. Only about half of the states have <u>any</u> limitations on third-trimester abortions, and many of these states have only very weak limitations.

Pro-abortion advocates often put forward unsubstantiated claims that third-trimester abortions are very rare (the figure of "about 100" a year is often asserted), and are performed only in the gravest emergencies. However, the *American Medical News*, the official newspaper of the American Medical Association, recently probed into this subject, interviewing two prominent abortionists who use the brutal "D&X" abortion method (which involves partially delivering a late-term baby, then stabbing the baby in the back of the head with a scissors). Both doctors-- quoted by name-- acknowledged that they perform what *they* termed "elective" abortions past 24 weeks. These doctors reside in California and Ohio, two of the states which have no enforceable restrictions on third-trimester abortions.

In 1984, then-Surgeon General C. Everett Koop estimated there were 4,000 *third-trimester* abortions a year-- a figure far removed from the "300-500" a year figure now disseminated by the National Abortion Federation. Dr. Martin Haskell, a prominent late-term abortion specialist, said that "probably Koop's numbers are more correct." [Copies of the entire *American Medical News* report are available on request from the National Right to Life Committee.]

On June 18, 1993, Barbara Radford, the executive director of the National Abortion Federation, issued a memorandum on the D&X issue. In this memo, Ms. Radford did *not* claim that all late-term abortions are performed for "medical" reasons. Rather, she wrote, "There are many reasons why women have late abortions: life endangerment, fetal indications, *lack of money or health insurance*, *social-psychological crises*, *lack of knowledge about human reproduction*, *etc.*" [emphasis added]

Under the Clinton plan, American employers and workers would be compelled to pay for all of these abortions-- including elective abortions *in the third-trimester*, abortions involving the brutal "D&X" stabbing method, and any other abortions.

Would the Clinton proposal really pay even for abortions performed to choose the sex of the child to be born?

Clearly, under the Clinton bill, no health plan would be permitted to refuse payment for abortions performed because a baby was not of the sex desired by the parent(s). The Clinton bill explicitly provides:

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> The items and services in the comprehensive benefit package shall not be subject to any duration or scope limitation or any deductible, copayment, or coinsurance amount that is not required or authorized under this Act. [S. 1757, page 34.]

Many pro-abortion advocates try to evade this issue by claiming that sex-selection abortions are seldom performed. However, there is growing evidence that this practice-- already endemic in some other nations-- is rapidly increasing in the United States. As recently as December 20, 1993, *USA Today* reported:

> But doctors and geneticists are increasingly concerned that some women are asking for and receiving early genetic tests solely to determine the sex of their fetuses.... Lawrence Platt, chairman of Obstetrics and Gynecology at Cedars-Sinai Medical Center in Los Angeles, says he thinks there are "thousands" of women who each year seek genetic testing just to determine their fetuses' sex.... But while many doctors say the issue raises a host of thorny ethical questions, others say it's just another medical service.... In a 1973 study, Platt found that only 1% of geneticists approved of performing fetal tests solely to determine sex. In 1988, another study found that number had grown to 20% who said they thought such testing was acceptable.

How would the Clinton plan vastly increase the number of persons permitted to legally perform abortions?

The Clinton bill would multiply the number of abortion providers by nullifying current state laws that prohibit non-physicians from performing abortions.

Currently, there are many American communities in which no abortionist is found. According to the Alan Guttmacher Institute, 83 percent of American counties have no abortion provider. Clearly, many health care providers recognize that abortion is not merely a routine "health benefit."

However, as explained above, under the Clinton plan, no health plan could be sold to the public unless it included some local source of abortion on demand.

One way in which the necessary additional providers would be created is found in the provision of the Clinton plan that would empower the National Health Board to override state laws that determine the professional qualifications required to provide specific medical services:

> No State may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals. [S. 1757, page 95.]

Right now, 46 states permit abortions to be performed legally only by licensed physicians. These so-called "doctor only" laws are coming under increasing criticism from pro-abortion advocates who want to legalize abortions by certified nurse-midwives, physician assistants, and nurse practitioners-- but the state legislatures have not been eager to repeal these laws. It is absolutely predictable that under the Clinton plan, those laws would be invalidated by the National Health Board, thereby multiplying the number of people who could provide legal abortions.

The Alan Guttmacher Institute, the research/propaganda arm of the Planned Parenthood Federation of America, took special note of this provision in the Clinton "Health Security Act" (HSA):

> HSA would make other improvements in insurance coverage that would have important ramifications for reproductive health care coverage. It explicitly covers the services of "health professionals," not just those of physicians, and states would be prohibited from adopting arbitrary bans on the provision of services by nonphysicans, such as

> nurse midwives and nurse practitioners. Instead, they would be limited to restrictions that could be justified by the "skill and training" of the providers. (AGI *Washington Memo*, November 9, 1993)

This provision of the Clinton bill is consistent with one of the essential "principles for health care reform" issued by the Planned Parenthood Federation of America:

> [to] eliminate unneeded reliance upon physicians and encourage the delivery of services by appropriately trained nurse practitioners, nurse midwives, physicians assistants and other health professionals.

How could the Clinton plan be "fixed" with respect to abortion?

It would require substantial revision in order to render the Clinton proposal "harmless" on abortion. The necessary revisions include:

-- language to explicitly exclude abortion from the government-defined benefits package

-- language to prevent the proposed National Health Board from later adding abortion to the benefits package

-- language to prevent federal nullification of state laws that place constitutionally permitted limits on abortion, including parental consent laws, "doctor-only" laws, certain limits on late-term abortions, and waiting periods.

Various Members of Congress have proposed various alternatives to the Clinton health care plan. Would these competing proposals also pay for abortions?

Some would, some would not. Basically, for any bill that would establish a government-defined "benefits package," it is necessary to add language to explicitly exclude abortion from that package. For any bill that creates a federal "health board" or other agency with authority to define a benefits package, language must be added to insure that the board has no authority to mandate abortion services.

For example, the legislation proposed by Sen. John Chafee (R-RI) and Rep. Bill Thomas (R-Ca.) (S. 1770, HR 3704) would create a standard benefits package that includes "medically necessary or appropriate... medical and surgical services"-- terminology that would certainly be interpreted to include elective abortion, as Sen. Chafee himself acknowledged. ("Under our plan...that [abortion] would be considered a normal service, although we don't specifically say so-- a normal medical service," Sen. Chafee has said.) NRLC opposes this legislation unless it is suitably amended.

The same is true of legislation proposed by Rep. Jim Cooper (D-Tn.) and Senator John Breaux (D-La.) (HR 3222, S. 1579). Under the Cooper-Breaux bill, virtually anybody who wants to buy health insurance would have to buy (at a minimum) a government-defined "uniform benefits package." The bill mandates that this package would include all "medically appropriate" services, broadly defined. In letters sent to Rep. Cooper and Sen. Breaux on February 17, 1994, seven organizations (with aggregate memberships totaling over 19 million persons) said they opposed the bill at least "unless it is amended to exclude abortion from the government-mandated benefits package." The signing organizations were the Southern Baptist Convention (Christian Life Commission), National Right to Life Committee, Christian Coalition, Family Research Council, American Family Association, Concerned Women for America, and Eagle Forum. Copies of these letters are available on request from NRLC.

The "single-payer" bill proposed by Rep. McDermott (D-Wa.) and Sen. Wellstone (D-Mn.) (HR 1200, S. 491) would require government-funded abortion on demand, and is therefore opposed by NRLC unless it is suitably amended.

Health care bills proposed by Sen. Nickles (R-Ok.) and Congressman Stearns (R-Fl.) (S. 1743, HR 3698); by Rep. Michel and Sen. Lott (HR 3080, S. 1533); and by Sen. Phil Gramm (R-Tx.) (S. 1796, S. 1807), do not contain provisions that would result in government promotion of abortion. NRLC does not oppose these bills.

Didn't Congress already vote to require abortion coverage in federal employees' health insurance plans?

No. Under the Federal Employees Health Benefits program, federal employees receive coverage from over 300 private health plans. In 1993, Congress-- by a razor-thin vote in each house-- removed a ten-year-old *prohibition* on including abortion in FEHB-administered health plans. This had the effect of *permitting, but not requiring* these health plans to pay for abortions. As a result, a number of major FEHB health plans added abortion coverage, but others did not. As discussed above, under the Clinton plan, *every* health plan would be required to pay for abortion on demand.

[Whereupon, at 2:25 p.m., the subcommittee was adjourned.]

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